4/1/2025

RWHAP Part B Services Standards

VIRGINIA DEPARTMENT OF HEALTH

Revised: March 31, 2025

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Division of Disease Prevention

HIV care Services

Foreword

The Ryan White Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) Program (RWHAP) Part B exists to ensure the highest quality core medical care and supportive services for People with HIV (PWH) in Virginia, as well as to provide medication access to them through statewide leadership and stakeholder collaboration.
The aim of the Virginia RWHAP Part B Clinical Quality Management Program (CQM) is to continuously improve the quality of care and services for people with HIV, and to be compliant with recognized Department of Health and Human Services Guidelines, National Priorities, Health Resources and Services Administration (HRSA) Monitoring and Service Standards, and research-based best practices.

Service Standards are revise once every two years and are updated in collaboration with the Quality Management Advisory Committee and subrecipients to reflect the most current nationally recognized guidelines in HIV care and treatment and local Virginia requirements. The Standards of Care are publicly available and can be accessed online or by contacting the RWHAP B Program. The full list of services covered by these standards is provided in the table of contents. In these pages you will find the Virginia Department of Health (VDH), Division of Disease Prevention (DDP), HIV Care Services (HCS) Unit, RWHAP Part B Standards for Core and Support Services.

Standards listed below are applicable to all service categories funded under the Ryan White Part B program. These standards are compliant with the HRSA/HAB Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part B Recipients issued June 2023. Recipients are required by HRSA/HAB to adhere to these monitoring standards and as such, sub-recipients funded for Ryan White Part B services will be held to the same standards.

Subrecipients must develop protocols and procedures meeting these standards, with the goal of serving residents of the Commonwealth in a consistent, timely, and informed manner. The Standards of Service are effective as of April 1, 2025.

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GLOSSARY OF ACRONYMS

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
AUDIT - DAST	Alcohol Use Disorders Identification Test – Drug Abuse Screening Test
CAR	Client Access Reviews
CMS	Centers for Medicare and Medicaid
CPAP	Community Pharmaceutical Assistance Program
EIS	Early Intervention Services
FDA	Food and Drug Administration
FPL	Federal Poverty Level
GAD	7 General Anxiety Disorder
HAB	HIV/AIDS Bureau
HHS	Health and Human Services
HIMAP	Health Insurance Marketplace Program
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
ICAP	Insurance Continuation Assistance Program
LCSW	Licensed Clinical Social Worker
LMSW	Licensed Master Social Worker
LPAP	Local Pharmaceutical Assistance Program
MNT	Medical Nutrition Therapy
MOA	Memoranda of Agreement
MoCA	Montreal Cognitive Assessment
MOU	Memoranda of Understanding
MPAP	Medicare Part D Prescription Assistance Program
NMS	National Monitoring Standards
OAHS	Outpatient Ambulatory Health Services
OTC	Over the Counter
PBM	Pharmacy Benefit Management
PCN	Policy Clarification Notice
PHQ-9	Patient Health Questionnaire
PrEP	Pre-Exposure Prophylaxis
RWHAP	Ryan White HIV/AIDS Program
TrOOP	True Out-of-Pocket Costs
UEA	United Eligibility Assessment
VAMAP	Virginia Medication Assistance Program
VDH	Virginia Department of Health

UNIVERSAL ADMINISTRATIVE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Universal Standards are the minimum requirements that providers are expected to meet when providing HIV care and supportive services funded by Ryan White Part B.

Objectives:
To ensure that providers are complying with contract provisions and state and federal requirements for Part B funded services. The objectives help achieve the goals of each service type by ensuring that programs:

- Have policies and procedures in place to ensure quality of care.
- Provide patients with access to the highest quality of services through experienced, trained, and, when appropriate, licensed staff.
- Guarantee patient confidentiality and ensure a fair process of grievance review.
- Comprehensively inform patients of services and establish patient eligibility.
- Address patient needs effectively through coordination of care with appropriate providers and referrals to needed services.
- Are accessible to all people with HIV in Virginia.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

1.0 Intake and Eligibility
As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP Par B services when they meet each of the following criteria:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02.)

2. **Low- Income:** The RWHAP Part B recipient is low-income. Low-income may be determined based on 500 percent of the Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. **Residency:** The RWHAP Part B recipient resides within a specified service area

Standard	Measure
Eligibility	
1.1) The client's eligibility for Ryan White Part B services is determined.	Documentation of the client's eligibility is present in the client's record.

1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service, applicants must: a) Be diagnosed with HIV (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third-party payers such as private and commercial insurance plans, and other payers that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP Part B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency. • Client eligibility ensures Part B services are used as the payer of last resort and *other funding sources must be vigorously pursued***.** Client must agree to participate in the insurance option that the client is eligible for and that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap in services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.
<u>Client Access Reviews/Continuation of Eligibility</u>	
1.3) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP Part B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	Documentation of CARS and continuation of eligibility is present in the client's record.

Access to Care	
1.4) Ensure people with HIV participate in quality committees and contribute to public meetings.	Documentation of people with HIV participating in committees and contributing to public meetings noted in meeting minutes.
1.5) Provide content, use, and confidentiality of client satisfaction surveys or focus groups conducted at least annually.	Documentation of content, use, and confidentiality of client satisfaction surveys or focus groups conducted at least annually.
2.0 Key Services Components and Activities	
Standard	**Measure**
Documentation	
2.1) Documentation in client record of all HIV Care Services provided.	Documentation of provided service is in client's record, signed and dated.
An initial phone or in-person screening will be completed within 72 hours of referral or contact by the client, including: • Current information, inclusive of date of birth • Scheduled date of first appointment • Source of referral & date of first contact by client • Documentation of language interpretation and/or other required accommodations for first visit	Documentation of initial intake in client file.
The intake process must be completed within 30 days of initial screening with client unless otherwise specified within the Service-Specific Standards. A completed intake will include the following documentation: • Demographic information, inclusive of date of birth, sex at birth, gender identity, race, ethnicity, & primary/preferred language • Source of referral & date of first contact by client • Source of payment, inclusive of all forms of insurance and benefits • Scheduled date of first appointment • Assessment of immediate service needs	Completed intake, dated no more than 30 days after initial screening, in client's file.
2.2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record must contain: • Referral	Documentation of provided services, signed, and dated records, including referral in record.

• Initial assessment • Individualized treatment plan, including treatment modality and frequency and quantity of treatments • Documentation of all contacts & dates of service • Reassessment of treatment plan to include monitoring and assessment of client progress • Referrals and follow-ups • Discharge plan Must sign and date all reports	
Transition and Discharge	
2.3) Client discharged when outpatient ambulatory health services are no longer needed, goals have been met, upon death or due to safety issues. <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter* must be sent to client's last known address. Must return letter to provider if the client is not present to sign. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. Case managers will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable	Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter*, if applicable. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. Case managers will document this in progress notes and discharge summary.* Discharge summary and other records sent with the patient

Transfer: If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. The three attempts should start no later than three months prior to the due date. A certified letter* must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state case closure within 30 days from the date on the letter if no appointment is scheduled with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. Case managers will document this in progress notes and discharge summary.* Withdrawal from Service: If client reports no longer needing services or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure understanding reasons for withdrawal. If client still needs services, identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency, clients should be referred to appropriate resources. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership, according to that agency's policies,	Document attempts made

must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify of possible alternative resources. A certified letter* that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. Case managers will document this in progress notes and discharge summary.*	
Recipient Accountability	
2.4) VDH reviews documentation at the subrecipient level to determine methods used for obtaining client input into the delivery of services.	Review documentation at the subrecipient level to determine methods used for obtaining client input into the delivery of services.
2.5) VDH will not deny services for non-payment, require full payment prior to service, and/or require any other procedure that denies services for non-payment.	Policy and procedures on file.
2.6) Review limitations on charges policies and procedures to ensure that they do not result in denial of services.	Documented review of limitations on charges policies and procedures.
2.7) Investigate any complaints against the subrecipient for denial of services.	Documentation of investigation results.
2.8) Review subrecipient billing, collections, copays, and schedule of charges. Review file of refused clients and client complaints.	Documentation of review on file.
Subrecipient Responsibility	
2.9) Maintain a file of materials documenting the consumer committee's membership and meeting attendance, including minutes.	Documentation of the consumer committee's membership and meeting attendance, including minutes.
2.10) Regularly implement client satisfaction survey tools, focus groups, and/or public meetings, with analysis and use of results documented.	Documentation of client satisfaction survey tools, focus groups, and/or public meetings, with analysis and use of results provided.
2.11) Ensure that billing, collections, copays, and schedule of charges and limitation of charges policies do not act as a barrier to	Policy and procedures on file.

receiving services, regardless of the client's ability to pay.	
2.12) Services are accessible to eligible individuals.	Site visit including, but not limited to, review of hours of operation, location, access to transportation, and other accessibility factors. Patient satisfaction surveys and patient interviews that address accessibility. Agency eligibility policy on file.
3.0 Client Rights and Responsibilities	
Standard	**Measure**
3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility assessments, *regardless of where they receive services*. Providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act (ADA). All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services based on the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	Written eligibility requirements and non-discrimination policy on file.
3.2) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have been offered: a) explanation of the policy, and b) copy of *Client's Rights and Responsibilities* and to communicate client's understanding of the policy**.**	Written policy on file.

3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include: • Being treated with respect, dignity, consideration, and compassion. • Receiving services free of discrimination. • Being informed about services and options available. • Participating in creating a plan of services. • Reaching an agreement about the frequency of contact and either in person or over the phone. • Filing a grievance about services received or denied. • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats. • Voluntarily withdrawing from the program. • Having all records be treated confidentially. Having information released only when: • A written release of information is signed. • A medical emergency exists. • There is an immediate danger to the client or others. • There is possible child or elder abuse. • Ordered by a court of law. **Client responsibilities include:** • Treating other clients and staff with respect and courtesy. • Protecting the confidentiality of other clients. • Participating in creating in a plan of service. • Letting the agency know any concerns or changes in needs. • Making and keeping appointments and, if necessary, phoning to cancel or change an appointment time.	Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Staying in contact with the agency by informing the agency of changes in address and/or phone number, as well as responding to phone calls and mail. • Not subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	
4.0 Grievance Process	
Standard	**Measure**
4.1) Grievance Policy requires each client to sign & date, indicating they have been offered: a) explanation of the policy, b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, if they have any complaint, or concern about the services received.	Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	Documentation of client grievances, status, and resolution.
4.4) Review of grievance policy yearly with client signature.	Current *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.

5.0 Personnel Qualifications (including licensure)	
Standard	**Measure**
5.1) Staff members have the minimum qualifications expected for the job position, which must include: a) education. b) experience; and c) licensure or certification requirements.	Resume in personnel file meeting the minimum requirements outlined in job description. Current job descriptions on file.
5.2) Staff members are licensed as necessary to provide services.	Copy of license or other documentation in personnel file, which covers the current or retroactive period services were provided.
5.3) Staff receives at least one hour of clinical supervision per month.	Signed documentation on file indicating date of supervision, persons in attendance and agenda.
5.4) All staff members receive on-going training and education in accordance with the service standards.	Copy of continuing education and training requirements maintained in personnel file.
6.0 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Health services are culturally and linguistically competent, client-guided and community based. At a minimum, provider's documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted. b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services. c) List of cultural competency trainings completed by staff.	Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	Culturally and linguistically appropriate materials and signage accessible.

7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act compliance were applicable.	Written Client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.
7.3) Store each client's file in a secure location with electronic client records protected from unauthorized use.	Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protected and access limited to appropriate personnel.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.
8.0 Quality Management	
Standard	**Measure**
8.1) Clinical Quality Management Program (CQM) that include: a) agency-specific quality statement. b) defined Quality Management (QM) infrastructure. c) annual quality goals, and work plan. d) performance measures and data collection plan. e) process for evaluating QM program; and f) communication strategy for informing key stakeholders.	Written CQM plan on file at provider agency.
8.2) Quality Improvement projects (QIPs) Develop annual projects and submit quarterly reports to VDH.	Written QIP plans and quarterly reports on file at provider agency.

8.3) Measure and report patient outcomes using measures approved by Virginia Department of Health.	Collection and reporting of data to VDH for use in measuring performance.
8.4) Develop and utilize a methodology to measure patient satisfaction with services, which may include a written satisfaction survey, staff, and volunteer observation of the patient, and/or interaction with the patient.	Documentation of patient satisfaction survey results and/or summary of observations/interactions with patients.
8.5) Implement improvements identified in the CQM.	Documentation of change ideas implemented.
8.6) Participate in periodic peer review to assess the quality and appropriateness of health and support services supported by Part B.	Documentation of the participation in peer review process.

RWHAP CORE MEDICAL SERVICES

AIDS DRUG ASSISTANCE PROGRAM TREATMENT STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02¸ Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost-effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance:
HRSA RWHAP Parts A, C, and D recipients may contribute RWHAP funds to the RWHAP Part B ADAP for the purchase of medication and/or health care coverage and medication cost sharing for ADAP-eligible clients.

Virginia Ryan White Part B Service Unit Definition:
One ADAP medication pick-up with one or more ADAP medications (e.g., five medications picked up at one time = one unit).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
Documentation	
1) Document provision of ADAP services by: a) Client eligibility b) Number of individuals served **c)** Medications provided.	Documentation of ADAP services provided.
Provision of Services	
2) Provide a formulary of medications to people with HIV for the treatment of HIV disease and the prevention of opportunistic infections. The formulary must include pharmaceutical agents:	Documentation of medication formulary.

a) From all the approved classes of antiretroviral medications in the PHS Clinical Practice Guidelines for use of Antiretroviral Agents in HIV-1 infected Adults and Adolescents b) Be FDA approved. *Note:* A process must be used to secure the best price available for all products on the formulary including 340B pricing or better.	
3) ADAP secures the best price available for all products including 340B pricing or better. The Federal 340B Program is a drug, price control program that allows qualifying providers to purchase outpatient drugs from manufacturers at discounted prices. All 340B pharmacy and medical claims must be submitted with the appropriate indicators and modifiers.	Documentation of: A process to secure the best available for all products on the formulary including 340B pricing or better.
4) Provide outreach (awareness) to individuals with HIV, and as appropriate the families of such individuals regarding ADAP and its programs to facilitate access to treatments for such individuals and to document progress in making therapeutics available.	Documentation of state's efforts and methods used to raise awareness.
5) Encourage, support, and enhance adherence to and compliance with treatment regimens, including medical monitoring. Activities include: • Enabling individuals to gain access to medications • Supporting adherence to the individual's prescribed drug regimen to receive the full health benefits afforded by the medications. • Providing services to monitor the client's progress in taking HIV-related medications.	Documentation of activities undertaken to improve access to medications and increase and support adherence to medication regimens.
6) Data sharing agreement in place with the Centers for Medicare and Medicaid (CMS) for the purpose of tracking True Out of Pocket Costs (TrOOP) for ADAP clients with Medicare Part D for whom ADAP is paying Medicare Part D Premiums, co-pays and deductibles.	Documentation of amount of ADAP funds used to pay TrOOP for clients with Medicare Part D and a signed data sharing agreement between ADAP and CMS.

Note: A data system necessary to track and account for ADAP payments for TrOOP costs must be established. These systems may be located at the ADAP's PBM.	
7) Facilitate client access to ADAP medication programs via: • Direct purchase medication program for clients not eligible for other programs or awaiting open enrollment • Insurance program • Medication co-pay, co-insurance, and deductible assistance •	Documentation of: • Medication distribution system for directly dispensing physician-prescribed medications to eligible clients • Insurance purchasing program for eligible clients ▪ Health Insurance Marketplace Program (HIMAP) assists with co-pays, co-insurance, and deductible • Medication co-pays, co-insurance, and deductible assistance for eligible clients ▪ Insurance Continuation Assistance Program (ICAP) ▪ Medicare Part D Assistance Program (MPAP)
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using ADAP measures approved.	Performance measurement data on the following indicators: • ADAP clients receiving medications or medication co-payments and/or deductibles, regardless of age, will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. • Percentage of people enrolled in RWHAP Part B-funded Program living with HIV and receiving ADAP services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

AIDS PHARMACEUTICAL ASSISTANCE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

AIDS Pharmaceutical Assistance may be provided through one of two programs, based on HRSA RWHAP Part funding.

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

HRSA RWHAP Parts A or B recipients using the LPAP to provide AIDS Pharmaceutical Assistance 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 that is
    - o Approved by the local advisory committee/board, and
    - o Consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's HRSA RWHAP Part B ADAP
    - o A statement of need should specify restrictions of the state HRSA RWHAP ADAP and the need for the LPAP
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

2. A Community Pharmaceutical Assistance Program (CPAP) is provided by a HRSA RWHAP Part C or D recipient for the provision of ongoing medication assistance to eligible clients in the absence of any other resources.

HRSA RWHAP Parts C or D recipients using CPAP to provide AIDS Pharmaceutical Assistance must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV-related medications not otherwise available to the clients
- Implementation in accordance with the requirements of the HRSA 340B Drug Pricing Program (including the Prime Vendor Program)

Program Guidance: For LPAPs: HRSA RWHAP Part A or Part B (non-ADAP) funds may be used to support an LPAP. HRSA RWHAP ADAP funds may not be used for LPAP support. LPAP funds are not to be used for emergency or short-term financial assistance. The Emergency Financial Assistance service category may assist with short-term assistance for medications.

For CPAPs: HRSA RWHAP Part C or D funds may be used to support a CPAP to routinely refill medications. HRSA RWHAP Part C or D recipients should use the Outpatient/Ambulatory Health Services or Emergency Financial Assistance service categories for non-routine, short-term medication assistance. See also AIDS Drug Assistance Program Treatments, Emergency Financial Assistance, and Outpatient/Ambulatory Health Services.

Virginia Ryan White Part B Service Unit Definition:
One AIDS Pharmaceutical Assistance *medication pick-up with one or more medications (e.g., five medications picked up at one time = one unit).*

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities

Standard	Measure
1) LPAP Prescriptions: Providers may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the THMP program does not cover. A copy of the client's prescription from the prescribing provider is on file with the agency. The prescription must include: • Name of the client • Date of Birth • Medication • Dose • Signature of prescribing medical provider	Percentage of client charts that have the documented prescriptions funded through LPAP assistance with name of client; date of birth; medication, dose; and signature of prescribing medical provider.
2) Timeliness of Service: Agencies must have a system for clients to access prescriptions. Prescriptions should be available and approved for LPAP assistance within two (2) business days. Otherwise, eligible clients shall have ongoing access to medications prescribed by a qualified prescribing medical provider through the local area's LPAP program so long as the medication	Percentage of clients accessing services under LPAP have access to their prescribed medication(s) that are not on the State Formulary within two (2) business days of approved LPAP-funding.

is on the LPAP formulary and allocations permit.	
3) Prescribed Over the Counter (OTC) medications: LPAP can assist clients with their OTC medications if the provider has prescribed the medication and has deemed the medication is needed for prevention and treatment of opportunistic infections (OI) or to prevent the serious deterioration of the client's health AND the medication is on the LPAP formulary.	Percentage of client files with prescribed OTC medications paid through LPAP funding have documented evidence from prescribing provider of medical necessity.
4) Medication Adherence Counseling: Clients are offered counseling on medication adherence when assistance is requested.	Percentage of clients who have documented evidence of adherence counseling offered at the time of assistance request.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using LPAP measures approved.	Performance measurement data on the following indicators: • LPAP clients receiving medications or medication co-payments and/or deductibles, regardless of age, will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. • Percentage of people enrolled in RWHA Part B-funded Program living with HIV and receiving LPAP services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

EARLY INTERVENTION SERVICE (EIS) STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

RWHAP Parts A and B EIS services must include the following four components:

1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be with HIV.
    a. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
    b. HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
2. Referral services to improve HIV care and treatment services at key points of entry.
3. Access and linkage to HIV care and treatment services such as HIV. Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Use Disorder Care.
4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

(Note: HIV testing does not need to be funded by RWHAP B funds. If the HIV testing is provided by another agency and the other three components are handled by an RWHAP B-funded agency, the service can still be recorded as EIS.)

Virginia Ryan White Part B Service Unit Definition:

All four components must be completed to receive one unit:

1. Completing one targeted HIV testing effort,
2. One referral to HIV medical care,
3. One linkage to HIV care or treatment, and
4. One outreach and health education/risk reduction unit.

(Note: If any of the four conditions are not present, each component must be billed to the appropriate service category. A client should receive only one EIS unit.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Subrecipients will establish Memoranda of Understanding (MOUs), with key points of entry to care, to facilitate care access for those who test positive.	Number of MOUs established with key points of entry.
A. HIV Testing and Targeted Counseling	
2) Clients are screened for health insurance, other sources of reimbursement, and/or other benefits	Completed documentation of client assessment of coverage in client's file
3) Provision of HIV testing and targeted counseling services that meet CDC and state requirements.	Documentation to include: • Number of HIV tests and targeted counseling services provided that meet CDC and state requirements. • Number of HIV-positive tests. • Where and when Part B-funded HIV testing occurred.
B. Referral Services	
4) Referral for EIS services shall be from key points of entry to include, but not limited to public health departments, emergency rooms, substance use disorder and mental health treatment programs, detoxification centers, detention facilities, sexually transmitted disease clinics, homeless shelters, HIV/AIDS counseling and testing centers, community corrections, jails, and federally qualified health centers.	Number of referrals from key points of entry to EIS programs.
5) Except for HIV testing, a referral by a Ryan White Part B provider is made for initiation of services. No referral is required if HIV testing is performed as part of EIS.	Documentation of the referral by a Ryan White Part B provider is present in the client's record, signed and dated, except for HIV testing.

6) Linkage agreements in place with Outpatient Ambulatory Health Services and HIV Prevention services	Copies of Memorandum of Understanding (MOU) are available. Referrals are documented in the client chart.
7) For persons who test negative, refer to HIV prevention services, including Pre-exposure prophylaxis (PrEP).	Number of referrals for prevention services for persons who tested HIV-negative.
8) For persons who test positive, refer and link to health care and supportive services, such as outpatient/ambulatory health services, medical case management and substance use disorder care.	Number of referrals for health care and supportive services for persons who tested HIV-positive.
9) As necessary, refer client to other appropriate services, (e.g., mental health, substance use disorder treatment).	Documentation of referrals made and status of outcome in client's record.
C. Linkage to care	
10) Linkage agreements in place for outpatient/ambulatory health services and HIV prevention services.	Copies of MOUs or Memoranda of Agreement (MOA) are made available.
11) HIV positive clients are referred to a primary medical care provider or an infectious disease provider for initial lab work	Referral date and date of initial lab work are documented in the client chart.
12) Follow-up with clients who are not engaged in HIV medical care until the client is in care. Providers must prioritize clients who have been recently diagnosed or have been out of medical care for longer than six months and who experience barriers to care such as: a) Active or recent substance use disorder issues b) Active or recent mental health issues c) Recent or chronic incarceration d) Homelessness or unstable housing e) Recent change in income	Follow up date and date in the client chart.
13) As necessary, HIV positive clients are referred to medical case management, substance abuse treatment and other core medical services	Referral date and provider documented in client chart.
14) Care will be coordinated across the HIV care team and specifically address engagement in care.	Documentation of consultation with medical staff, mental health, and other support services, as appropriate.
15) Develop a service plan with the client, to be assessed every 90 days for evaluation of progress and emerging needs.	Documentation of initiated service plan signed and dated by client and support counselor.

D. Health Education and Literacy Training	
16) Conduct an individual assessment of client's knowledge of HIV risk and transmission, disease progression and the health care delivery system	Completed assessment filed in client chart.
17) Based on the results of the assessment, provide health education, risk reduction and literacy training to help individuals understand the HIV diagnosis and navigate the HIV system of care.	Documentation of education provided in client's record.
18) Service plan is reassessed every 90 days to assess progress and identify emerging needs.	Documentation of review and update of the plan as appropriate signed and dated by client and support counselor.
19) Assess if health education and literacy training to staff support both HIV positive and negative clients to meet their needed health goals.	Health education sessions outcomes are documented in client chart.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Staff shall have knowledge and understanding of HIV testing, HIV education, the criminal justice system, services for PWH, and medical systems. Staff shall have experience working with people experiencing homelessness, mental health conditions, substance use disorder issues, and developmental delays.	Personnel records contain documentation of completed disease intervention specialist or HIV testing training, as appropriate. Personnel records contain documented training/experience in working with people with substance use disorder/addiction, issues of poverty, mental illness, developmental delays, and criminal justice system.
2) Staff qualifications: a) Staff providing care and/or counseling services to clients participating in the Early Intervention program must be trained to provide these services to recently diagnosed HIV clients and to PWH who know their status and are not in care. b) All agency staff that provide direct-care services shall possess: • Advanced training/experience in HIV/infectious disease. • Early intervention HIV skills and abilities as evidenced by training, certification, and/or licensure, and	Evidence of training will be documented in the staff personnel records

documented competency assessment. • Skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel.	
3) Staff Training: Within three (3) months of hire, all staff must complete a minimum of sixteen (16) hours of training regarding the target population and the HIV service delivery system in the service area, including but not limited to: • The full complement of HIV/AIDS services available within the selected areas • How to access such services [including how to ensure that subpopulations can access services (i.e., undocumented individuals)] • Eligibility for other sources of funding under entitlement and benefit programs other than Ryan White services. Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care. Evidence of training will be documented in the staff personnel records	Evidence of training will be documented in the staff personnel records
<u>Quality Management</u>	
Standard	**Measure**
Measure and report client health outcomes using Early Intervention Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people enrolled in RWHAP Part B-funded Program with HIV regardless of age and receiving EIS services, who will have at least one care marker* in a 30-day period. ** Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test*

	date, and/or an antiretroviral medication prescription and date

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HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients 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 clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client including deductibles, coinsurance, copayments, and incurred costs not covered for clients with insurance.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance assistance), an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- Clients obtain health care coverage that at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services; and
- The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, an HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost effective in the aggregate and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

Program Guidance:
Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost sharing assistance. If a HRSA RWHAP Part C or Part D recipient

has the resources to provide this service, an equitable enrollment policy must be in place, and it must be cost-effective.

HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost sharing.

Virginia does not do the above suggestion, Virginia HIPCSA will be used by subrecipients for cost sharing on behalf of uninsured and underinsured clients since we have Insurance Benefit Management setup, and we use ADAP for premium payment and medication cost shares.

Virginia Ryan White Part B Service Unit Definition:
One medical office visit (**and/or**) lab copayment; cost share for insured client not enrolled in an ADAP insurance-based service option; (**or**) a copayment/cost-share for insured clients for core medical services (e.g., mental health, oral health, substance abuse treatment).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Virginia RWHAP Part B Insurance Benefit Management/Pharmacy Benefit Management does not use HIPCSA – activities from BMs are applied to ADAP Services costs.

Key Services Components and Activities	
Standard	**Measure**
Documentation	
1) All Health Insurance Premium and Cost-Sharing Assistance Services provided is documented in client record.	Documentation of Health Insurance Premium and Cost-Sharing Assistance Services is in client's record, signed and dated.
Assessment/Service Plan/Provision of Services	
2) An initial assessment of client's core and support service needs to be completed prior to the initiation of the service plan.	Documentation of assessment in client's record signed and dated.
3) Within fifteen (15) days after the initial assessment, a service plan will be developed in collaboration with the insurance assistance staff and client, which will identify the scope of insurance services, cost limitations, timeframes, and client responsibilities. The client will be offered a copy of the plan. *Note:* No direct payments will be made to clients.	Documentation of service plan in client's record signed and dated by the case manager and the client.

4) Service plan is reassessed every 90 days to assess status and identify emerging needs.	Documentation of review and update of the plan as appropriate and signed and dated by staff and the client.
5) Assist VDH-contracted Insurance Benefits Manager with the client's enrollment in health insurance programs to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients. *Note:* Purchased health coverage plan must include at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents and provides comprehensive primary medical care.	Documentation of the health insurance premiums providing the OAHS and pharmacy benefits in client chart.
6) Paying non-medication-related cost-sharing (including deductibles, coinsurance, copayments, and incurred costs not covered for clients with insurance) on behalf of eligible clients. *Note:* Cost-sharing may include co-pays for prescription eyewear for conditions related to HIV infection. If funds are used to cover co-pays for prescription eyewear, a physician's written statement confirming the eye condition is related to HIV infection is required.	Documentation of co-sharing payment in client's record.
7) Providing funds to contribute to an eligible client's Medicare Part D true out-of-pocket (TrOOP) cost.	Clients maintain their Medicare Part D coverage and advance through the self-pay/donut hole tier of Part D into the Catastrophic Tier (final tier)
8) Refunds or payments by the insurance company to the policyholder must be signed over to or reimbursed to the RWHAP Part B.	Provide a mechanism through which clients are aware of this policy and can submit refunds or payments to the CARE Program.
9) Payments cannot be made directly to the client by the RWHAP Part B to reimburse for any payments previously made by the client.	Provide a mechanism through which payment can be made on behalf of the client.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All insurance benefit management assistance staff will have	Copy of qualifications in employee personnel file.

a minimum of an associate degree and one year of insurance experience including knowledge concerning COBRA, OBRA, Medicaid, Medicare, and private insurance programs.	
2) Newly employed insurance personnel must complete orientation within 2 weeks of hire and the following training within 180 days of hire: • HIV 101 • Affordable Care Act • Insurance Marketplace • Medicare Part D • Cultural competency • Legal ramifications, including confidentiality.	Documentation of training in personnel file.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Health Insurance Premium and Cost Sharing measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Health Insurance Premium and Cost Sharing Assistance services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP B-funded Program with HIV and receiving Health Insurance Premium and Cost Sharing Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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HOME AND COMMUNITY-BASED HEALTH SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance: Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Virginia Ryan White Part B Service Unit Definition:
One home health provider visit (in-person or virtual) per day for uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
An initial assessment is conducted within 72 hours of referral	Completed assessment form in client file with documentation of date of referral and assessment completion.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Nursing services are provided by Home Health Nurses who are licensed as required by the State of New Hampshire	Resume and documentation of licensure for each staff member funded to provide services in personnel files at the agency.
2) Homemaker services are provided by a Licensed or otherwise credentialed agency or staff person, either directly or via subcontract.	Resume and documentation of licensure for each staff member funded to provide services in personnel files at the agency.

Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Home and Community-based Health Service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people enrolled in RWHAP B-funded Program with HIV and receiving Home and Community-based Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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HOME HEALTH CARE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

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

Program Guidance: The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Virginia Ryan White Part B Service Unit Definition:
One home health provider visit (in-person or virtual) per day for uninsured clients.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) An initial assessment is conducted within 72 hours of referral.	Completed assessment form in client file with documentation of date of referral and assessment completion.
2) Home Health Care services are documented in a client file. Files must contain: • Type, dates, and location of services • Initial and subsequent assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress	Client files document services that are dated and signed by the by professional who provided the service

• Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	
3) Provision of the following services as indicated: • Appropriate mental health, developmental, and rehabilitation services • Day treatment or other partial hospitalization services • Home health aide services and personal care services in the home • Durable medical equipment	Documentation that: • Care is provided by professionals certified in their jurisdictions to provide services in the home and community-based setting • Only allowable services are provided • Services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services • The care plan specifies the types of services needed and the quantity and duration of services
4) An initial comprehensive assessment is performed on the client by the appropriate provider in alignment with the referral, including reason for the service	Documentation of comprehensive assessment in client's file signed and dated by the provider
5) A reassessment is performed on the client by the appropriate provider at the frequency established in the treatment plan, not to exceed six months	Documentation of reassessment in client's file signed and dated by the provider
6) A comprehensive medical history will be taken at least once a year and, at a minimum, must include: • New Symptoms • Medications (all) • Knowledge of HIV regimen • HIV transmission risk behaviors and risk reduction methods • Sexual history • Behavioral Health • Alcohol and recreational drug use • Tobacco use • Allergies • Pain • Social supports • Housing	Documentation of a comprehensive medical history that is signed and dated by the provider

• Insurance • Intimate partner violence	
7) A treatment plan must be updated after each assessment. At a minimum, it must include: • Current treatments and other interventions as indicated • Date and signature of professional who provided the service	All referrals for HIV specialty care and/or other RWHAP Part B services is documented
8) A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client, including recommendations as to the appropriate level of care • Planning for continuity of care, including assistance making the transition from one care setting to another • Collaborative approaches to health, including frequency of medical visits	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
9) Clients not following up with Home Care in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management or patient navigator services is documented in the client file and is signed and dated.
10) All referrals for HIV specialty care and/or other RWHAP Part B services is documented	Documentation of each referral is signed and dated
Personnel Qualifications (including licensure)	
1) Must be licensed by the appropriate state and/or local authority to provide skilled nursing services. Must show evidence of professional malpractice insurance in addition to insurance requirements of Shelby County.	Documentation on file
2) Skilled nurse a registered nurse (RN) who provides appropriate skilled nursing care to client in their place of residence in accordance	Documentation on file

with Documentation on file State / federal regulations. Provides services required in the treatment plan of care; performs duties consistent with the nursing practice standard of competent performance. Licensed vocational nurse (LVN) is a health professional who works under the supervision of a physician or RN. LVN performs basic care services, taking vital signs, temperature, blood pressures, treating bedsores, and giving injections.	
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Home Health Care measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Home Health Care, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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HOSPICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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: Hospice 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 as established by the recipient. 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 respective state Medicaid programs.

Virginia Ryan White Part B Service Unit Definition:
One hospice service provider visit (in-person or virtual) per day for uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Physician Certification for Hospice Services: The attending physician must certify that a client is terminal, defined under Virginia Medicaid hospice regulations as having a life expectancy of six (6) months or less. The certification must specify that the individual's prognosis is for a life expectancy	Documented evidence of clients receiving Hospice services with attending physician certification of client's terminal illness documented in the client's primary record.

of six (6) months or less if the terminal illness runs its normal course. The certification statement must be based on record review or consultation with the referring physician. The referring physician must provide orders verbally and in writing to the Hospice provider prior to the initiation of care and act as that patient's primary care physician. Physician orders are transcribed and noted by the attending nurse.	Documented evidence of clients receiving Hospice care with documentation in the primary record of all physician orders for initiation of care.
2) Health Assessment: A comprehensive health assessment is completed for each client within 48 hours of admission. Identifies the patient's need for hospice services in the areas of medical, nursing, social, emotional, and spiritual care. Hospice provider documents each client's scheduled medications, including dosage and frequency. HIV medications may be prescribed if discontinuance would result in adverse physical or psychological effects. Hospice provider documents needed (PRN) medications for clients and includes client's name, dose, route, reason, and outcome.	Documented evidence of clients in Hospice care with a documented comprehensive health assessment completed within 48 hours of admission in the client's primary record. Documented evidence of clients in Hospice care with documentation of all scheduled and PRN medications, including dosage and frequency, noted in the client's primary record.
3) Implementation of Care Plan: A written care plan based on the provider's orders is completed for each client within seven (7) calendar days of admission and reviewed monthly.	Documented evidence of clients in Hospice care with a written care plan based on physician's orders completed within seven calendar days of admission documented in the client's primary record. Documented evidence of clients in Hospice care with documented evidence of monthly care plan reviews completed in the client's primary record.
4) Palliative Therapy: Palliative therapy must be documented in the written plan of care with changes communicated to the referring provider. Palliative therapy is care designed to relieve or reduce the intensity of uncomfortable symptoms but not to produce a cure.	Documented evidence of clients in Hospice care with a written care plan that documents palliative therapy as ordered by the referring provider documented in the client's primary record.

5) Provision of Bereavement Counseling Services for Hospice: Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. A hospice must have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. A hospice must: • Develop a bereavement plan of care that notes the kind of bereavement services to be offered to the patient's family and other persons and the frequency of service delivery. • Hospice providers must make bereavement services available to a patient's family and other persons in the bereavement plan of care. • Ensure that bereavement services reflect the needs of the bereaved. Although Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding CANNOT pay for these services per legislation.	Documented evidence of bereavement counseling offered to family members upon admission to hospice services in the client's record.
5) Provision of Dietary Counseling for Hospice: Dietary counseling means education and interventions provided to a patient and family regarding appropriate nutritional intake as a hospice patient's condition progresses. Dietary counseling, when identified in the plan of care, must be performed by a qualified person. • A qualified person includes a dietitian, nutritionist, or registered nurse.	Documentation of clients in Hospice care with evidence of dietary counseling provided, when identified in the written care plan, in the client's primary record.

6) Provision of Spiritual Counseling for Hospice: A hospice must provide spiritual counseling that meets the patient's spiritual needs in accordance with their acceptance of this service and in a manner consistent with their beliefs and desires. A hospice must: • Provide an assessment of the client's spiritual needs. • Make all reasonable efforts to the best of the hospice's ability to facilitate visits by local clergy, a pastoral counselor, or other persons who can support a client's spiritual needs; and advise the client of the availability of spiritual counseling services.	Documentation of offered spiritual counseling, as appropriate, documented in the written care plan in the client's primary record
7) Provision of Mental Health Counseling for Hospice: Mental health counseling should be solution focused; outcomes oriented and have a time limited set of activities for the purpose of achieving goals identified in the patient's individual treatment plan. Mental Health Counseling is to be provided by a licensed Mental Health professional (see Mental Health Service Standard and Universal Standards for qualifications): • The patient's needs as identified in the patient's psychosocial assessment • The patient's acceptance of these services	documented evidence of mental health counseling offered, as medically indicated, in the client's primary record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
Physician Certification for Hospice Services:	Copy of qualifications in employee personnel file.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Hospice Service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of clients receiving Hospice services with attending

	physician certification of client's terminal illness documented in the client's primary record • Percentage of clients in Hospice care with a written care plan based on physician's orders completed within seven calendar days of admission documented in the client's primary record

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MEDICAL CASE MANAGEMENT, INCLUDING TREATMENT ADHERENCE SERVICE STANDARD

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- 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
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance: Activities provided under the Medical Case Management service category have as their objective improving health care outcomes, whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category, whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following: Ryan White HIV/AIDS Program (RWHAP) - Universal Monitoring Standards (UMS) - Fiscal and Program Standards for RWHAP Part A and Part B Recipients

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

MEDICAL NUTRITION THERAPY STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Medical Nutrition Therapy includes:

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

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

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

Virginia Ryan White Part B Service Unit Definition:
One visit with a registered dietician (**or**) one pick-up of a prescribed case of a medical nutritional supplement.

(In accordance with HAB PCN #16-02, the provision of Medical Nutritional Therapy must be conducted by a registered dietitian. Issuing nutritional supplements without a dietician falls under Food Bank and Home Delivered Meals.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities (including assessment and service plan)	
Standard	**Measure**
Documentation	
1) Provision of all medical nutrition therapy (MNT) services is documented in client files. Files must contain: • Services provided • Number of clients served	Documentation of MNT services provided by services. Client files document services that are dated and signed by the by professional who provided the service

• Quantity of nutritional supplements and food provided. Types, dates, and location of services • Initial and subsequent nutrition evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by the professional who provided the service	
2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record must contain: a) Services provided & dates b) Nutritional Plan c) Physician's recommendation for provision of food. All reports must be signed and dated by the third party.	Signed, dated reports located in the client's record.
Assessment/Service Plan/Provision of Services	
3) Clients self-referring for services will be screened to determine need for MNT prior to an initial MNT assessment.	Documentation of screening in client's record signed and dated.
4) An initial MNT assessment of client's needs to be completed by a Dietitian or Nutritionist to include, at a minimum, anthropometrics, clinical, dietary, and laboratory data.	Documentation of MNT assessment in client's record signed and dated.
5) Within seven (7) business days after the initial assessment, a MNT plan will be developed and agreed upon by the client and provider to include, at a minimum:	Documentation of MNT plan in client's record signed and dated.

• Nutritional diagnosis, medical information, weight, and current diet • Provide recommended services and course of MNT, including types and amounts of nutritional supplements • Date service is to be initiated • Planned number and frequency of sessions.	
6) Provide clients with nutritional supplements and food according to the MNT plan and provider's recommendation. *Note:* A provisional two (2) week supply of nutritional supplements and/or food may be given to eligible clients while obtaining the provider's recommendation.	Documentation of MNT services provided in client's record signed and dated.
7) Provide nutritional counseling, health education and educational materials to increase client's knowledge of healthy food choices, benefits of good nutrition, etc.	Documentation of nutritional counseling and health education in client's record signed and dated.
8) MNT plan is reassessed each quarter to assess progress and identify emerging needs. Revised MNT plan is to be shared with the primary care provider.	Documentation of review and update of the plan as appropriate signed and dated.
9) Refer client to other services as appropriate, e.g., mental health, community resources, exercise facilities.	Documentation of referrals made and status of outcome in client's record.
10) Clients not following up with Medical Nutrition Therapy in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management services or patient navigator services is documented in the client file and is signed and dated.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Dietitians and Nutritionists must have appropriate and current licensure as required by the Commonwealth of Virginia. *Note:* There is currently no licensing law in Virginia for nutritionists and dieticians. Nutritionists and Dieticians must meet the education/training and experience requirements specified in the Code of Virginia.	Documentation of qualifications and current licensure in personnel file.

2) Dietitians and Nutritionists must complete 2 hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of required continuing education in personnel file.
3) Staff has the knowledge, skills, and experience appropriate to providing food or nutritional counseling/education services.	Personnel records, resumes, employment applications, document requisite education, skills, and experience.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Medical Nutrition Therapy services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Medical Nutrition Therapy services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Medical Nutrition Therapy services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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MENTAL HEALTH SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients with HIV. The services are based on treatment plans 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.

Program Guidance:
Mental Health Services are allowable only for HIV-diagnosed clients.

Virginia Ryan White Part B Service Unit Definition:
One mental health provider visit (in-person or virtual) per day* for uninsured client OR one mental health visit copayment or cost share for insured client.

*An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit (A mental health counselor and a psychiatrist visit on the same day at the same facility = 1 unit).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
Documentation	
1) Documentation of all mental health services provided in client record. If psychotropic medications are used, include the medication list, assessment of side effects, and treatment education information.	Documentation of mental health service is in client's record, signed and dated.
2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record must contain: • Referral • Initial assessment	Documentation of provided service is signed and dated in client record.

• Individualized treatment plan, including treatment modality and as clinically necessary, weekly or biweekly, for as long as needed • Documentation of all contacts & dates of service • Reassessment of treatment plan to include monitoring and assessment of client progress • Referrals and follow-ups • Discharge plan • Must sign and date all reports.	
Assessment/Service Plan/Provision of Services	
3) Individuals have sufficient information about the service to provide informed consent for mental health services	Client file includes signed and dated consent form. Therapeutic disclosure will be reviewed and signed by all participants and must be compliant with NH Mental Health statutes.
4) Completion of a mental health screening for determination is required. Mental health screenings include: a) PHQ-9 b) GAD-7 c) AUDIT-DAST d) Rx Abuse Screener e) Montreal Cognitive Assessment (MoCA)	Documentation of screening signed and dated by mental health service provider.
5) Client minimum assessment including behavioral health, biological, psychological, and social history will be conducted within 7 days of client's first visit to the clinic. All assessments must be documented in client's file within 24 hours of the assessment and must contain the clinician's signature and date. The result of the assessment will be used to complete the service plan as necessary.	Documentation of mental health assessment in client's file signed and dated by the provider. Update the progress note if clients initially prioritize medical needs and are not ready to engage in behavioral health care.
6) If mental health services are deemed appropriate, a service plan is developed within 30 days of the initial screening to include: • Diagnosed mental illness or condition • Service modality (individual or group or both) • Treatment goals • Start date for mental health services	Documentation of service plan in client's record signed and dated by mental health service provider. If client is unable to sign the treatment plan, progress note should include documentation that the client has received a copy.

• Projected end date for services • Recommended number of sessions • Reassessment dates of client progress every 90 days.	
7) Mental health services, provided as group or individual sessions, should be specific to individual client needs and can include counseling topics including, but are not limited to: a) Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors b) Substance abuse c) Treatment adherence d) Development of social support systems e) Community resources f) Maximizing social and adaptive functioning g) The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals.	Documentation of mental health services provided in client's record signed and dated.
8) Care will be coordinated across the agency and specifically address monitoring mental health and treatment adherence.	Documentation of consultation with medical staff, mental health, pharmacy, and other support services, as needed.
9) Review of service plan at least every 90 days and modify it as appropriate.	Documentation of review and update of service plan as appropriate, signed and dated.
10) A written plan for crisis management must be updated after each assessment and developed collaboratively with the client. The client is offered a copy of the plan. At a minimum, it must include: • Signs of behavioral health crisis. • Supports available; and • Coping skills.	When possible, documentation of a treatment plan that is signed and dated by the client must be in client's file. If no client signature and date by the client, an explanation must be in client's file.
11) Refer client to other medical, mental health, and other services as appropriate, e.g., psychiatric services, substance abuse treatment,	Documentation of referrals made and status of outcome in client's record.

neuropsychological testing, day treatment programs, in-patient hospitalization, and case management.	
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All mental health professionals will have appropriate and valid licensure and certification as required by the Commonwealth of Virginia. Where applicable, the following licensure is required for: • Licensed Clinical Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Marriage and family therapist • Licensed professional counselor • Psychologist • Psychiatrist • Psychiatric nurse.	Copy of current licensure in personnel file.
2) Newly employed mental health professionals must complete orientation within 90 days of hire and include training on: • Referral for crisis intervention policy/procedures • Standards of care • Confidentiality • Client rights and responsibilities • Client abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data management and record keeping.	Documentation of training completed in personnel file.
3) All mental health professionals must complete at least 2 hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of training complete in personnel file
4) Supervision is required of all mental health professionals by a licensed clinical mental health practitioner.	Documentation of supervision according to agency policy.

Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Mental Health Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Mental Health Services, regardless of age, with at least **two Ryan White Part B service encounters** in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Mental Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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ORAL HEALTH CARE STANDARDS

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

Program Guidance:
None currently.

Virginia Ryan White Part B Service Unit Definition:
One visit for uninsured client (**or**) one oral health visit copayment or cost share for dental-insured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components

Standard	Measure
Documentation	
1) Oral Health services are documented in a client file. Files must contain: • Types, dates, and location of services • Initial and subsequent oral health evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the professional who provided the service
2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agency's record must contain: • Referral	Documentation of provided services, signed and dated records, including referral in record.

• Initial assessment • Individualized treatment plan, including treatment modality, frequency and quantity of treatments • Documentation of all contacts & dates of service • Reassessment of treatment plan to include monitoring and assessment of client progress • Referrals and follow-ups • Discharge plan. • Must sign and date all reports.	
Assessment/Service Plan/Provision of Services	
3) Perform a comprehensive oral history and assessment on all clients referred for oral health care. History and assessment include: • Dental and medical history • Assessment of the oral cavity • Assessment of extra-oral and intra-oral hard and soft tissue • Medication history • Assessment for HIV-specific oral manifestations • Appropriate X-rays to assist with diagnosis and treatment • Periodontal screening/examination • Client complaints. Initial comprehensive history and assessment may require two visits.	Documentation of comprehensive oral history and assessment in client's record signed and dated.
4) For clients receiving preventive and therapeutic services, update Oral Health Treatment Plan at least every 6 months.	Documentation of updated Oral Health Treatment Plan in client's record at least every six months, signed and dated.
5) Clients referred for Oral Health Care Services should have an annual oral evaluation to include periodontal screening/examination.	Documentation of annual oral examination in client's record, signed and dated.
6) Client referrals to other services as appropriate, e.g., dental specialty care.	Documentation of referrals made and status of outcome in client's record, signed and dated.
7) Client education to encourage seeking routine dental care as recommended by the American Dental Association.	Documentation in the client's record encouraging the client to seek routine dental care, as recommended by the American Dental Association.

8) Offer appropriate dental education material to the client.	Note in the client's record the offered materials such as appropriate dental education material visible in the waiting room.
9) Have the client complete a consent form for dental services.	Documentation that the Ryan White overseeing agency has given consent for the dental services.
10) Give treatment priority to pain, infection, traumatic injuries, or other emergency conditions	Documentation that treatment priority was given to pain, infection, traumatic injuries, or other emergency conditions.
Baseline evaluation	
12) Include in evaluation: a completed medical history, existing oral conditions, patient's chief complaint, medical alerts (if appropriate), radiographs (if appropriate for an accurate diagnosis and treatment), and drug history.	Documentation in the client's record signed and dated of a baseline evaluation.
Treatment Plan	
13) For cavities, missing teeth, and periodontal conditions, diagnoses must be made for each quadrant or sextant to address these conditions. Conduct a full mouth series of radiographs to substantiate periodontal disease. If periodontal disease exists, perform a full mouth probing every six months.	Documentation in the client's record showing concurrence with the standards.
14) Have the treatment plan reviewed and updated as needs are identified or at least every 6 months.	Documentation signed and dated that the treatment plan was reviewed and updated as needs are identified or at least every 6 months.
15) Have the treatment plan evaluated by appropriate staff.	Approval documentation on file.
16) Have all services provided recorded signed and dated.	Documentation signed and dated that all services provided recorded.
17) Have all the prescriptions and drugs dispensed signed and dated.	Documentation signed and dated in the client's record of prescriptions and drugs dispensed.
18) Give post-operative instructions to client for surgical procedures.	Documentation signed and dated in the client's record post-operative instructions given for surgical procedures.

19) Have record of all pre-medications and local anesthetic used signed and dated.	Documentation signed and dated in the client's record of all pre-medications and local anesthetic used.
20) Identify if the provider is a third-party payer or not.	Documentation that provider is a third-party payer.
Extractions	
21) Assess the client need for replacement teeth.	Documentation of the client need for replacement tooth/teeth due to no other viable options such as removable or fixed prosthesis, and/or cone beam analysis results.
Documentation	
22) Keep updated records including medical history, Physical examination, Laboratory reports, Medications, Treatment plan of care, Interim progress notes, Laboratory reports, Referrals, and follow-ups.	Documentation signed and dated in the client's record of medical history, Physical examination, Laboratory reports, Medications, Treatment plan of care, Interim progress notes, Laboratory reports, Referrals and follow-ups.
<u>Personnel Qualifications (including licensure)</u>	
Standard	**Measure**
1) All oral health professionals, including third-party payers, have appropriate and valid licensure and certification as required by the Commonwealth of Virginia. • Dental practitioners, dental specialists and dental hygienists must be licensed by The Commonwealth of Virginia Board of Dental Examiners. • Dental Assistants who make x-rays must register with the Virginia Board of Dental Examiners.	Copy of current licensure/certification for staff providing services in personnel file.
2) Must have malpractice insurance.	Documentation of malpractice insurance on file.
3) Supervision of all dental hygienists and dental assistants by a licensed dentist.	Documentation of supervision according to agency policy.
4) All oral health professionals must complete 2 hours of continuing education in HIV/AIDS annually.	Documentation of training completed in personnel file.

Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Oral Health Care Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of persons with an HIV diagnosis who are receiving Oral Health education session in the 12-month measurement period

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OUTPATIENT/AMBULATORY HEALTH SERVICE STANDARDS

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as 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, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Emergency room and non-HIV-related urgent care visits are not allowable costs within the Outpatient/Ambulatory Health Services Category

Virginia Ryan White Part B Service Unit Definition:
One medical prescribing provider visit (virtual or in-person) per day per physician/group practice for an uninsured client (**and/or**) one individual lab test (e.g., a panel of five lab tests = five units) for uninsured clients.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
Documentation	
1) Documentation in client record of all OAHS provided. Files must contain: • Date of HIV diagnosis • Initial and subsequent health assessments, inclusive of medical history and comprehensive physical examination • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be signed and dated	Documentation of OAHS is in client's record signed and dated.
2) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agencies' record must contain: • Referral. • Initial assessment. • Individualized treatment plan, including treatment modality and frequency and quantity of treatments. • Documentation of all contacts & dates of service. • Reassessment of treatment plan to include monitoring and assessment of client progress. • Referrals and follow-ups; and • Discharge plan. • Must sign and date all reports.	Documentation of provided services, signed and dated records, including referral in record.
Assessment/Service Plan/Provision of Services	
3) Perform a comprehensive initial medical history and physical examination within 30 days of client contact with provider. Additional	Documentation of comprehensive medical history and physical assessment in client's record signed and dated by provider.

dimensions of the comprehensive history and assessment include: • Oral health assessment • Psychosocial/Mental health assessment • Substance use screening and assessment • Nutritional assessment. • TB Risk Assessment and TB Test with performance of or referral for additional evaluation as indicated (i.e., chest x-ray if positive test for TB infection or if active TB symptoms are identified).	Document referral to the Local Health Department for individuals with presumptive active tuberculosis.
4) Complete initial Physical Examination within 30 days of client contact with the provider.	Documentation of initial physical assessment in client's record signed and dated by provider.
5) Medical history assessment, which includes: • Drug allergies and current medications • New Symptoms • Medications (all) • HIV medication adherence screening • Adherence to medications and clinical care visits • Knowledge of HIV regimen • Reproductive and sexual health considerations • HIV transmission risk behaviors and risk reduction methods • Sexual history • Behavioral Health • Alcohol and recreational drug/substance use • Tobacco use • Social supports • Housing • Insurance • Intimate partner violence	Documentation of medical history in client's record signed and dated by provider.
6) Evaluate all persons with HIV for Latent Tuberculosis Infection (LTBI) at the time of HIV diagnosis, regardless of their epidemiological risk of TB exposure (AII). If the TB test is positive, refer for chest x-rays or other necessary follow-up tests. Mycobacterium tuberculosis Infection and Disease | NIH (hiv.gov)	Documentation of review all labs/skin test in client's record.

7) Develop a medical treatment plan in collaboration with the client and offer the client a copy of the medical plan. At a minimum, it must include: • Current antiretroviral treatment and other medications as indicated • Screening tests and vaccination recommendations/history	Documentation of the treatment plan in the client's record and a copy of the visit documentation which includes a care plan offered to patient. Include any TB-related treatment and follow-up in treatment plan.
8) If seen for a visit, the medical care plan is updated every six months or more frequently, as needed.	Documentation in the client record that the medical care plan is updated at least every six months if patient is seen for a visit, signed and dated by medical care provider
Follow-Up Visits	
A1) Provision of the following services in accordance with HHS HIV Treatment Guidelines as part of the treatment of HIV infection: • Diagnostic testing, including laboratory testing • Early intervention and risk assessment • Preventive care and screening • Physical examination • Medical history • Diagnosis, treatment, and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling, and referral • Prescription and management of medication therapy • Access to antiretroviral therapies, including combination antiretroviral treatment and prophylaxis and treatment of opportunistic infections • Treatment Adherence • Education and counseling on health and prevention issues • If indicated: Pediatric developmental assessment/Well-baby care • Referral to and provision of HIV-related specialty care related to HIV diagnosis. *Note:* Must provide care in outpatient setting, such as clinic, medical office, or mobile van. Only allowable services can be provided. Specialty medical care relates to HIV infection	Documentation of services in client's record signed and dated by provider.

and/or conditions arising from the use of HIV medications resulting in side effects.	
A.2) History, minimum q. 6 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.
A.3) Physical Exam, minimum q. 6 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.
A.4) Laboratory Testing, minimum q. 6 months, or p.r. n	Documentation of services in client's record signed and dated by provider.
A.5) Medication history reviewed at each visit, which includes new: a) Drug allergies b) Current medications c) Drug/substance abuse d) Treatment adherence	Documentation of services in client's record signed and dated by provider.
A.6) Oral health assessment, referral, and/or annual/routine dental care to be completed	Documentation of Oral Health assessment, referral, and/or annual/routine services in client's record signed and dated by provider.
A.7) Nutritional assessment or referral to be completed	Documentation of services in client's record signed and dated by provider.
A.8) Current (in last year) ophthalmology or optometry eye exam or referral if any of the following are met: • CD4 < 100 • Diabetes mellitus • hypertension	Documentation of services in client's record signed and dated by provider.
A.9) Breast exam to be completed, where **applicable** (females)	Documentation of current breast exam, where applicable in the client's record. (females)
A.10) Follow up from referrals documented	Check documentation of follow up from referrals in the client's record.
Laboratory	
B.1) CD4, q. minimum 12 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.
B.2) Viral Load (HIV/RNA), minimum q. 6 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.
B.3) CBC, minimum q.12 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.
B.4) Chemistry Panel, minimum q. 6 months, or p.r.n.	Documentation of services in client's record signed and dated by provider.

B.5) Toxoplasmosis Antibody Titer at baseline if CD4< 200.	Documentation of services in client's record signed and dated by provider.
B.6) Resistance Genotyping /Phenotyping, p.r.n. a) Genotypic resistance testing (baseline; treatment failure) b) Phenotypic resistance testing (known virologic failure; known complex drug resistance pattern(s)	Documentation of services in client's record signed and dated by provider.
B.7) Lipid Panel (annually)	Documentation of services in client's record signed and dated by provider.
B.8) Urinalysis (baseline & annually if any of the following are met: • CD4 counts <200 cells/μL • HIV RNA >4000 copies/mL • diabetes mellitus • hypertension • hepatitis C virus coinfection • on TDF (tenofovir difumarate) or TAF (tenofovir alafenamide))	Documentation of services in client's record signed and dated by provider.
B.9) Liver/Hepatic Panel (baseline; minimum annually)	Documentation of services in client's record signed and dated by provider.
B.10) Glucose (if not in Chem Panel; baseline& annually); Hemoglobin A1C minimally annually or p.r.n.	Documentation of services in client's record signed and dated by provider.
B.11) Hepatitis A serology at baseline	Documentation of services in client's record signed and dated by provider.
If negative, patient referred for Immunization	Documentation of services in client's record signed and dated by provider.
B.12) Hepatitis B serology at baseline, before switching to an ART regimen that does not include tenofovir in persons without known HBV infection or immunity, and p.r.n. ongoing risk factor behavior	Documentation of services in client's record signed and dated by provider.
If negative patient referred for Immunization	Documentation of services in client's record signed and dated by provider.
B.13) Hepatitis C serology at baseline and annually if initially negative and increased likelihood of exposure (including sexually	Documentation of services in client's record signed and dated by provider.

active cisgender men and transgender women who have sex with cisgender men and people who inject drugs) or when clinically indicated	
If positive, patient evaluated and /or referred	Documentation of services in client's record signed and dated by provider.
B.14) STI risk assessment evaluated at each visit (e.g. Syphilis, Gonorrhea, Chlamydia), when patient is sexually active	Documentation of services in client's record signed and dated by provider.
B.15) Asked about STI symptoms at each visit, when patient is sexually active	Documentation of services in client's record signed and dated by provider.
B.16) VDRL, syphilis IgG as first test and then reflex to RPR and FTAbs q12 months with reports on the record, when patient is sexually active	Documentation of services in client's record signed and dated by provider.
B.17) TB risk factors reviewed annually and p.r.n,	Documentation of services in client's record signed and dated by provider.
B.18) TB testing (TST or interferon-based testing) at initial presentation, repeated if baseline CD4+ was < 200 but has risen to > 200, and p.r.n based on risk factor and symptom review	Documentation of services in client's record signed and dated by provider.
B.19) For all WWH Age <30 years: no HPV testing unless abnormalities are found on Pap test. **Age Specific:** Age <21 years: Pap test within 1 year of sexual activity, no later than age 21 years. Age 21–29 years: Pap test at diagnosis of HIV, repeat every 12 months × 3, then if all normal, Pap test every 3 years.	Documentation of services in client's record signed and dated by provider.
B.20) Women with HIV Aged ≥30 years: Cervical cancer screening in WWH should continue throughout a woman's lifetime (and not, as in the general population, end at 65 years of age). Options: • Pap test only, same as age 21–29 years. Or	Documentation of services in client's record signed and dated by provider.

• Pap test with HPV testing, if both negative, then Pap test with HPV every 3 years.	
B.21) Mammogram annually for those with breasts ages 50-75 years with dates and results in the record	Documentation of services in client's record signed and dated by provider.
B.22) Chest x-ray at baseline for patients with positive TB testing or prn for underlying lung disease – dates and results in the record, education about LTBI risk provided, and initiation or referral for LTBI treatment if indicated?	Documentation of services in client's record signed and dated by provider. Documentation of LTBI treatment regimen, initiation date and completion date.
B.23) Special Studies-other testing based on individual needs. Dates and results in the record (as applicable)	Documentation of services in client's record signed and dated by provider.
B.24) Pre-pregnancy discussion and counseling for all women of childbearing age at baseline and routinely thereafter.	Documentation of services in client's record signed and dated by provider.
C.1) Current medications documented in the client's record	Are all current medications documented in the client's record?
Medications	
C.2) Medication adherence assessment done at each visit	Is medication adherence assessment with documentation done at each visit?
C.3) Medication side effects assessed and documented	Documentation of services in client's record signed and dated by provider.
C.4) When applicable, document client's AIDS diagnoses status	Does the client have a documented AIDS diagnosis?
C.5) Document if highly active antiretroviral therapy (HAART) has been offered to the client	Has HAART been offered to the client, when applicable?
C.6) Document if the client currently on HAART	Documentation of services in client's record signed and dated by provider.
C.7) Ensure HAART is consistent with current Department of Health and Human Services (PHS) Guidelines for the Use of Antiretroviral Agents in Adults Adolescents with HIV	Is HAART consistent with current PHS Guidelines?
C.8) Client on Pneumocystis jirovecii pneumonia (PJP) prophylaxis if CD4<200	Documentation in client's record signed and dated by provider.

C.9) Client on Toxoplasmosis prophylaxis if CD4<100	Documentation in client's record signed and dated by provider.
C.10) People with HIV who are not receiving ART or who remain viremic on ART but have no current options for a fully suppressive ART regimen should receive chemoprophylaxis against disseminated Mycobacterium avium complex (MAC) disease if they have CD4 counts <50cells/mm3(AI). *Primary prophylaxis against disseminated MAC disease is not recommended for adults and adolescents with HIV who immediately initiate ART (AII).	Documentation in client's record signed and dated by provider.
D.1) An appropriate outcome based medical plan of treatment developed with the client	Documentation of an appropriate outcome based medical plan of treatment developed with the client and present in the client's record.
Education and Prevention	
D.2) Client Education documented in the client's record?	Documentation of services in client's record signed and dated by provider.
D.3) Progress notes present, current, legible, signed and dated in the client's record.	Are progress notes present, current, legible, signed and dated in the client's record?
D.4) Prevention and Risk factor reduction/ Counseling message provided at each visit	Documentation of Prevention and Risk factor reduction/ Counseling message at each visit in client's record signed and dated by provider.
Immunizations	
E.1) Influenza (annually)	Documentation of services in client's record signed and dated by provider.
E.2) Pneumovax 23	Documentation of services in client's record signed and dated by provider.
E.3) Prevnar 13	Documentation of services in client's record signed and dated by provider.
E.4) Hepatitis A series- if serology is negative- is series completed	Documentation of services in client's record signed and dated by provider.
E.5) Hepatitis B series –if serology is negative –is series completed	Documentation of services in client's record signed and dated by provider.
E.6) Tetanus/Diphtheria (or Tdap x 1) (every/ ten years)	Documentation of services in client's record signed and dated by provider.

E.7) Others • Human Papillomavirus (HPV), • meningococcal, • COVID-19, • mpox, • Respiratory Syncytial Virus (RSV), and • Varicella-Zoster Virus (VZV) vaccinations based on current CDC guidelines	Documentation of services in client's record signed and dated by provider.
F.1) Is there adequate documentation of care provision in the client's record	Documentation of services in client's record signed and dated by provider.
Documentation	
F.2) Is there an initial history, physical, and laboratory reports in the client's record	Documentation of services in client's record signed and dated by provider.
F.3) Are all progress notes reflecting health status, response to treatment, and services provided to client	Documentation of services in client's record signed and dated by provider.
F.4) Are there current laboratory reports in the client's record	Documentation of services in client's record signed and dated by provider.
F.5) Are there current medication records, AIDS Drug Assistance Program (ADAP) (name of drug, dosage, time) in the client's record	Documentation of services in client's record signed and dated by provider.
F.6) Are appropriate referral and follow-up documented in the client's record	Documentation of services in client's record signed and dated by provider.
F.7) Is there documentation in the client's record that current standards of care for the HIV/AIDS client are practiced? If not, comment.	Documentation of services in client's record signed and dated by provider.
F.8) Provide laboratory tests integral to the treatment of HIV infection and related complications. Tests must be: a) Ordered by a certified, licensed provider b) Consistent with medical and laboratory standards c) Approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory	Documentation of laboratory tests performed in client's record, signed and dated.

Improvement Amendments (CLIA) Program.	
F.9) Refer clients not following up with Outpatient Ambulatory Health Services for six (6) months to case management or patient navigator services for re-engagement in care.	Documentation of attempts to contact client and referrals in the client's record signed and dated.
F.10) Refer client to HIV specialty care and/or other services as appropriate, e.g. mental health, substance abuse treatment.	Documentation of referrals made and status of outcome in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All physicians, physician's assistants, clinical nurse specialists and nurse practitioners will have appropriate and valid licensure and certification by the Commonwealth of Virginia.	Copy of current licensure/certification in personnel file.
2) All providers must complete their required continuing education in HIV/AIDS treatment or care annually.	Documentation of agency process to track completed trainings.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Outpatient Ambulatory Health Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

SUBSTANCE ABUSE OUTPATIENT CARE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

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

Syringe access services are allowable to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA or HAB-specific guidance.

Virginia Ryan White Part B Service Unit Definition:
One substance abuse provider visit (in-person or virtual) per day for RWHAP Part B eligible client.

(An additional visit on the same date of service at a different practice/site = one unit. All categories assume one or more client encounters per day with the same practice/site = one unit.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities (including assessment and service plan)	
Standard	**Measure**
Documentation	
1) Individuals have sufficient information about the service to provide informed consent for substance use disorder care services.	Client file includes signed and dated consent form. Therapeutic disclosure will be reviewed and signed.
2) All substance abuse services provided is documented in client record.	Documentation of substance abuse services are in client's record signed and dated.
3) When a third-party payer provides service, the sub-recipient must maintain a client record. At a minimum, the payer's record and the dental agencies' record must contain: • Referral. • Initial assessment. • Individualized treatment plan, including treatment modality and frequency and quantity of treatments. • Documentation of all contacts & dates of service. • Reassessment of treatment plan to include monitoring and assessment of client progress. • Referrals and follow-ups; and • Discharge plan. • Must sign (handwriting/electronic) and date all reports.	Documentation of provided services, signed, and dated records, including referral in record.
Assessment/Service Plan/Provision of Services	
4) An initial substance abuse assessment of client's needs to be completed within 10 days of initial contact with client and prior to the initiation of the service plan. Assessment to include: • Substance use history and status • Medical history and current health status • Availability of food, shelter, transportation, financial resources • Support system • Legal issues/custody status • Mental health status and co-existing conditions.	Documentation of assessment in client's record signed and dated.
5) If substance abuse services are deemed appropriate, a substance abuse treatment plan	Documentation of treatment plan in client's record signed and dated.

is developed within 15 days within date of the initial assessment to include: • Diagnosed condition • Treatment modality (individual or group) • Treatment goals • Start date for services • Projected end date for services • Recommended number of sessions • Reassessment dates of client progress. *Note:* Substance abuse services must be provided by or under the supervision of physician or other qualified/licensed personnel. (*See section 5.0 Personnel Qualifications)*	
6) A complete psychosocial assessment will be completed. Results of the assessment will be used to complete the treatment plan as necessary.	Documentation of complete psychosocial assessment in client's record signed and dated.
7) Substance abuse services, provided as group or individual sessions, should be specific to individual client needs. Progress notes should be completed for every counseling session and include: • Session date and duration • Focus of session and observations • Assessment and interventions • Newly identified issues/goals • Client's responses to interventions and referrals.	Documentation of substance abuse services and type of session provided in client's record signed and dated.
8) Treatment options shall be a joint decision between the client and provider and should address the full spectrum of substance use. Services are limited to the following: • Pre-treatment/recovery readiness programs • Harm reduction • Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse • Outpatient drug-free treatment and counseling • Opiate Assisted Therapy	Documentation of treatment modalities employed in client's record signed and dated. If provided, referral for services in client's record signed and dated.

• Neuro-psychiatric pharmaceutical • Relapse prevention • Limited acupuncture services. *Note:* For any client receiving acupuncture services, a written referral from the primary care provider must be in the client file.	
9) Treatment plan is reviewed at least every 12 sessions and modified as appropriate. If the client is retained in care for the review of the treatment plan, there should be documentation to the reason why treatment plan was not completed.	Documentation of review and update of treatment plan as appropriate signed and dated.
10) Refer client to other medical, mental health and other services as appropriate (e.g., psychiatric services, mental health services, in-patient hospitalization, case management). The type of referral and date should be documented. Follow up of referral should be noted (whether client attended, rescheduled or did not show).	Documentation of referrals made and status of outcome in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All substance abuse (outpatient) service providers and substance abuse counselors will have appropriate and valid licensure/certification as required by the Commonwealth of Virginia.	Copy of current licensure and/or certification in personnel file.
2) Newly employed substance abuse professionals must complete orientation within 90 days of hire and training included but not limited on: • Hepatitis B and C • Sexually Transmitted Diseases (including HIV) • Tuberculosis • Referral for crisis intervention policy/procedures • Confidentiality • Emergency and safety procedures • Cultural competency.	Documentation of training completed in personnel file.

3) All substance abuse professionals must complete two (2) hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of training completed in personnel file.
4) A written policy regarding regular supervision of all licensed staff will be in place.	Documentation of supervision according to agency policy.
5) The provider agency must be a licensed facility with outpatient substance use treatment designation and must comply with the rules and standards established by DBHDS.	Agency will have documentation on site that license is current for the physical location of the treatment facility.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Substance Abuse Treatment (Outpatient) measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Substance Abuse Treatment (Outpatient) Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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RWHAP SUPPORT SERVICES

CHILD CARE SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services).

Program Guidance: The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source, which should be carefully weighed in the decision process.

Virginia Ryan White Part B Service Unit Definition:
One child care service provided per day for uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

2.0 Key Services Components and Activities	
Standard	**Measure**
1) Child Care Services: Intermittent childcare services are provided for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.	Documented evidence of clients accessing childcare services on in the client's primary record of the HIV medical appointment, RWHAP-related meeting, group, or training session attended.
2) Providers and facilities providing services have appropriate and valid licenses, certifications, and/or registrations as required under applicable federal, state, and local laws	Documentation on file

Not Allowable	
• Direct cash payments or cash reimbursements to client or cash reimbursements to clients. • Off-premise social and/or recreational activities	
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Formal childcare (provided by a licensed or registered childcare provider to deliver intermittent care)	Copy of qualifications in employee personnel file.
2) Informal childcare (provided by a neighbor, family member, or other person)	Documentation on file
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Child Care Service measures approved by VDH.	Performance measurement data on this indicator: • Percentage of clients accessing childcare services that have documentation in the client's primary record must reflect the appointment and/or meeting/group/training session attended.

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EMERGENCY FINANCIAL ASSISTANCE STANDARDS

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

Program Guidance:
Account for Emergency Financial Assistance (EFA) funds used to pay for otherwise allowable HRSA RWHAP services under the Emergency Financial Assistance category. Do not permit direct cash payments to clients.

Do not fund continuous provision of an allowable service to a client through Emergency Financial Assistance.

Virginia Ryan White Part B Service Unit Definition:
*One food voucher, one month's rent, one essential utility payment;(**or**) short-term emergency housing 7 days or less.*

(EFA is limited one-time or short-term payments. Subrecipients must clearly document that Ryan White Part B is the payer of last resort for each EFA service provided to a client. It is expected that all other sources of funding will be effectively used prior to paying with Ryan White Part B funds. Continuous provision of an allowable service to a client should not be funded through EFA. Subrecipients cannot use EFA for medications on the ADAP formulary. Contact VA MAP to get Unified formulary medication for the client.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Emergency funds are allocated, tracked, and reported by type of assistance to include: • Number of clients and amount expended for each type of EFA	Documentation of EFA provided by type of assistance.

• Summary of number of EFA services received by client • Methods used to provide EFA (e.g., payments to agencies, vouchers). Must sign and date all reports.	
2) Client record must contain, at a minimum: • Need for EFA • Type(s) and date(s) of EFA provided • Method of providing EFA (e.g., vouchers, payment to agencies). *Note: Do not permit direct cash payment to client.* Must sign and date all reports.	Signed and dated reports verifying need, documenting assistance provided and method of providing EFA in the client's record.
Assessment/Service Plan/Provision of Services	
3) Complete a request for EFA prior to the provision of assistance.	Documentation of request for EFA in the client record signed and dated.
4) For those clients determined to need EFA services, develop an emergency assistance plan within 24 hours of providing emergency assistance.	For clients in need of EFA services, documentation of emergency assistance plan signed and dated.
5) Review the emergency assistance plan and reassess needs every 30 days for 3 months.	Emergency assistance plans reassessed every 30 days in client's record signed and dated.
6) Provide Emergency Financial Assistance (EFA) for essential services including: • Essential Utilities (including Water, Electricity, Sewage, internet service) • Housing (Emergency Housing 1-14 days and Short-term Housing 15-30 days) • Transportation • Food (including groceries, food vouchers, and food stamps)	Documentation of assistance provided for essential services with frequency and duration outlined in client's record signed and dated.
7) Any Food cards purchase with RWHAP funds will not be allowed greater than 90 days from time of use because anything beyond that is considered pre-purchase and the RWHAP is a reimbursement program. If subrecipients were to exceed 90 days, they would have to demonstrate that they could	Documentation of food cards purchased and delivered and number of clients.

issue, with supportive documentation, ALL the cards they purchased within 90 days. Do not permit VDH to allow any subrecipient or second level provider to stock up on quantities past the 90-day use metric or to stock up for next year with end-of-year spending for their grants.	
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Emergency Financial Assistance service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of persons with HIV and receiving Emergency Financial Assistance services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Emergency Financial Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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FOOD BANK/HOME DELIVERED MEAL STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

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

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the Ryan White HIV/AIDS Program (RWHAP).

Virginia Ryan White Part B Service Unit Definition:
One bag of food, voucher to food pantry, or delivered meal, one case of nutritional supplement.

(In accordance with HAB PCN #16-02, the provision of Medical Nutritional Therapy must be conducted by a registered dietitian. Issuing nutritional supplements without a dietician falls under Food Bank and Home Delivered Meals.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities

Standard	Measure
1) Provision of all Food Bank/Home Delivered Meals Services is documented by: • Initial and subsequent food bank/home-delivered meals evaluation and assessments • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated referrals and follow-up • All reports must be dated and signed by professional who provided the service	Documentation of Food Bank/Home Delivered Meals Services provided by type, level of service and number of clients.

• Type of service (e.g., food bank, home delivered meals and/or food vouchers) • Number of clients and amount expended for service.	
2) Documentation of compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals, and food voucher programs, including appropriate license and certification.	Food and safety inspection reports, current license and certifications are on file.
3) Any food cards purchase with RWHAP funds will not be allowed greater than 90 days from time of use because anything beyond that is considered pre-purchase and the RWHAP program is a reimbursement program. If subrecipients exceed 90 days, they must demonstrate that they can issue, with supportive documentation, all the cards they purchased within 90 days. VDH is not permitted to allow any subrecipient or second level provider to stock up on quantities past the 90-day use metric or to stock up for next year with end-of-year spending for their grants.	Documentation of food cards purchased and delivered and number of clients.
Assessment/Service Plan/Provision of Services	
4) An initial nutrition assessment must be completed by a licensed, registered dietitian, case manager, or provider prior to the initiation of food bank services or home-delivered meals. Including, at a minimum: • Access to food • Access to storage • Ability to prepare meals • Dietary restrictions • Inventory of other resources clients are utilizing to meet food and nutritional needs (ie. food pantry, congregate meals, commodity food programs, SNAP, etc.) A reassessment is performed with the client by the appropriate provider at the frequency established in the care plan	Documentation of nutrition assessment in client's record signed and dated.

5) Services may include food bank, home-delivered meals and/or food voucher program.	Documentation of services provided including tracking of food vouchers: • A copy of each food card number, staff who is giving out of the cards with date/signature of client • Number of cards given to client • Progress note written by case managers.
6) Provide educational materials to increase client's knowledge of healthy food choices.	Documentation of educational materials in clients' record is signed and dated.
7) Clients are provided information regarding the food distribution schedule and any changes to the schedule at least three days in advance of the distribution date except in cases of unforeseen emergency.	Posted schedule for distribution of food pantry items and home delivered groceries and meals and written policy for notifying clients of changes to the distribution dates.
8) <u>Nutritional Guidance</u> An agency nutrition plan is established for the purpose of distributing healthy foods that enhance an HIV client's nutritional, caloric and dietary needs. Food choices should be offered from recognized food groups for enhanced nutrition in the Food and Drug Administration (FDA) or American Dietetic Association (ADA) Standards. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
9) A provisional supply of nutritional supplements (from prescriptions) may be provided to clients. A physician's recommendation must specify the type and amount of nutritional supplement congruent with the current Medical Nutrition Therapy Service Standards.	Physician recommendation for nutritional supplements in client's record signed and dated.
10) Reassess the needs every 6 months. Minimum contact (telephone or face-to-face) every six months to verify address/phone number, to check on client's current food assistance need status. Service Plan update every 6 months.	Documentation in progress notes

Personnel Qualifications (including licensure)	
Standard	**Measure**
1) If a dietitian is employed, they must have appropriate and current licensure as required by the Commonwealth of Virginia.	Documentation of appropriate and current licensure in personnel file.
2) Cooks must have experience working in food service, including food preparation. Experience purchasing food is desirable.	Documentation of qualifications in personnel file.
3) All staff and volunteers for food bank or those that distribute food must complete the local food bank training program.	Documentation of training completed in personnel file.
4) If a dietitian is employed, they must complete 2 hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of training completed in personnel file.
5) Newly employed staff providing food bank or home delivered meals must complete orientation within 2 weeks of hire and the following training within 180 days of hire: • Safe food handling procedures • Confidentiality issues for delivery personnel • Sensitivity to the HIV/AIDS client • HIV nutrition guidelines/standards • Cultural competency • Food safety.	Documentation of training completed in personnel file.
6) All staff and volunteers providing food bank or home delivered meals must attend quarterly trainings provided by a Registered Dietitian on a variety of topics including: • Food purchasing • Food handling • Safety in the kitchen • HIV nutrition • Food temperature • Proper sanitation • Food packaging • Food storage procedures.	Documentation of training completed in personnel file.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Food Bank/Home Delivered Meals measures approved by VDH.	Performance measurement data on the following indicators:

	• Percentage of people with HIV and receiving Food Bank/Home Delivered Meals services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Food Bank/Home Delivered Meals services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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HEALTH EDUCATION/RISK REDUCTION STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

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

Program Guidance:
Health Education/Risk Reduction services cannot be delivered anonymously.

Virginia Ryan White Part B Service Unit Definition:
One Health Education/Risk Reduction encounter (regardless of time).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

2.0 Key Services Components and Activities	
Standard	**Measure**
1) All HE/RR services provided are documented in client record.	Documentation of HE/RR services are in client's record signed and dated.
Assessment/Service Plan/Provision of Services	
2) An initial health education/risk reduction and literacy level assessment is completed prior to the initiation of the HE/RR plan.	Documentation of assessment in client's record signed and dated.
3) Within 30 days after the initial assessment, a HE/RR plan will be developed and agreed upon by the client and health educator, outlining service goals, objectives, and interventions. The plan should be individualized based on the client's needs and include:	Documentation of HE/RR plan in client's record, signed and dated.

• Education about HIV transmission and how to reduce the risk of transmission to others • Information about available medical and psychosocial support services • Counseling on how to improve their health status. Other information may include: • Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention • Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage) • Health literacy • Treatment adherence education.	
4) HE/RR plan is reassessed every 90 days to assess client progress and identify emerging needs.	Documentation of review and update of HE/RR plan as appropriate, signed and dated by client and health educator.
5) Refer client to other services as appropriate, e.g., mental health, substance abuse treatment.	Documentation of referrals made and status of outcome in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) HE/RR staff must have a high school diploma or General Education Development (GED) and one year of experience working with people infected with HIV or additional health care training.	Documentation of qualifications in personnel file.
2) Newly employed HE/RR staff must complete the following training within 180 calendar days of hire: • HIV 101 • Treatment Adherence • Infection control/blood-borne pathogens • Confidentiality • Cultural competency • How to make a referral	Documentation of training completed in personnel file.
3) All HE/RR must complete 12 hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of required continuing education credits in personnel file.
4) HE/RR staff and volunteers must be supervised by a degreed or licensed individual	Documentation of supervision in staff and volunteers according to agency policy.

in the fields of health, social services, mental health or possess equivalent experience.	
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using HE/RR service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving HE/RR Services, regardless of age, with at least two RW Part B service encounters in a 12-month period that are at least 3 months apart.

DISCLAIMER: Ryan White Eligibility for the service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

HOUSING STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

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

Program Guidance:
HRSA RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms in place to assess and document the housing status and housing service needs of new clients and at least annually for existing clients.

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

Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits,6 although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards. Housing, as described here, replaces PCN 11-01.

Virginia Ryan White Part B Service Unit Definition:
*One initial individualized housing plan; one annual individualized housing plan update; one month's rent; one month's utilities; (**or**) one navigation service effort (search, placement, advocacy, referral, housing service coordination, inspection).*

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

2.0 Key Services Components and Activities	
Standard	**Measure**
1) Agency has a policy on file describing eligibility for housing services.	Documentation of policy on file.
2) Provision of all housing services is documented by: • Number of clients served • Duration of housing services • Types of housing provided • Housing referral services provided • Assistance provided to help clients obtain stable, long-term housing • Assurance that no Ryan White funds were used to provide direct payments to clients for rent, mortgage, or utilities, and no funds are used for security deposits until VDH has developed a policy to allow such use.	Documentation of housing services provided.
3) Client records must contain, at a minimum: • Housing and referral services provided • Individualized written housing plans • Individual service plan must be updated annually • Assistance provided to clients to help obtain stable long-term housing • Method of providing housing services (e.g., payment to agencies). *Note:* Housing services cannot be in the form of direct cash payment to client and cannot be used for mortgage payments. Housing funds may not be used to pay for security deposits until such time as VDH has developed a policy allowing subrecipients to do so. Must sign and date all reports.	Signed, dated reports located in the client's record.
Assessment/Service Plan/Provision of Services	
4) Complete an initial assessment of client's housing needs prior to the provision of service including at a minimum: • Housing barriers • Housing needs	Documentation of assessment in client's record signed and dated.

• Available resources A triage process needs to occur to determine if emergency housing is needed.	
5) Within seven (7) business days after the initial assessment, develop an individualized written housing plan. The housing plan is designed to help the client obtain or transition to stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation. Care plans must be updated at annually. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
6) Individualized housing plan is reassessed annually to determine the need for new or additional services.	Documentation of housing plan reviewed and revised annually in client's record signed and dated.
7) Housing-related referral services may include: • Housing assessment • Search, placement, and/or advocacy • Fees associated with any of these activities.	Documentation of housing-related referral services provided to enable the client or family gain or maintain outpatient/ambulatory health services and treatment.
8) Housing Services provide time-limited transitional, short-term, or emergency housing assistance. Eligible housing can include either housing that: • Provides some type of core medical and/or support services (such as residential substance use disorder services or • Does not provide direct medical or support services but is essential for a client or family to gain or maintain access and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.	Documentation of necessity of housing services for purposes of medical care in client's record signed and dated.

9) Housing funds may be used for application fees and rent payments.	Documentation of housing assistance types.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All staff who provide Housing-related referrals will be case managers or other professional(s)who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs	Documentation of qualifications in personnel file.
2) All housing staff must complete six (6) hours of continuing education in HIV/AIDS annually.	Documentation of continuing education credits in personnel file.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Housing Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Housing Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Housing Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

LINGUISTIC SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Linguistic Services include interpretation and translation activities, both oral and written to eligible clients. These activities 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 HRSA RWHAP-eligible services.

Program Guidance:
Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Virginia Ryan White Part B Service Unit Definition:
One provided linguistic service, including interpretation and translation activities, both oral and written, to eligible clients.

(Linguistic services include oral or written translation for a client to assist with language barriers.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Notification of the availability of language assistance services clearly visible and in their preferred language.	Visible signage in at least the top 15 languages notifying clients of the availability of language assistance services
1) Identification of client's language and communication access need to facilitate effective communication with service providers. The responsibility for identification rests with the provider, not with the client. If a language assistance need is suspected by the service provider, an interpreter should be offered.	Documentation of clients' preferred language or communication assistance need in client file signed and dated by the provider (e.g. spoken language interpreter, American Sign Language interpreter, Certified Deaf Interpreter, CART provider, etc).

3) All care/services are provided in the client's preferred language with communication access services provided as needed: • Interpretation: spoken or signed • In-person • Over the phone • Video remote • Assistive technology • Translated written materials • Large font materials, etc.	Documentation in client file whenever communication access services are provided (or waived) including date, modality, and provider/interpreter used.
4) Document provision of all linguistic services including the following: • Number and types of providers requesting and receiving services • Number of assignments • Languages involved • Types of services provided (oral or written) Type of client served (individual or group).	Documentation of linguistic services provided signed and dated.
Assessment/Service Plan/Provision of Services	
5) Interpretation (oral) and translation (written) services provided to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. *Note:* Due to confidentiality issues and medical terminology limitations, client's family members and friends will not be considered as ongoing interpreters.	Documentation of Linguistic Services in client's record signed and dated.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Linguistic Services are provided by qualified medical interpretation and translation professionals and/or bilingual staff whose language competence has been assessed. • Interpreters have completed 60 hours of qualifying medical interpretation training (or equivalent) and may even have certification or licensure where applicable • Bilingual staff have degree of language fluency for speaking, reading and writing assessed	Linguistic competence and proficiency can be verified (documented on resumes, in contracts, or through testing)

2) Oral and written translators are encouraged to be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI). Staff and volunteers who provide interpreting services for the deaf or hard of hearing are encouraged to have Virginia Quality Assurance Screened Level III credentials.	Qualifications documented in personnel record.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Linguistic Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of persons living with HIV and receiving Linguistic Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Linguistic Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

MEDICAL TRANSPORTATION SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client 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 clients
- 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.

Virginia Ryan White Part B Service Unit Definition:
*Payment for a one-way trip to a medical or other allowable service that enables a client to access or be retained in core medical and support services (**or**) one voucher for travel to a medical or other allowable service that enables a client to access or be retained in core medical and support services.*

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

2.0 Key Services Components and Activities

Standard	Measure
1) Documentation of all medical transportation services provided by type of transportation, date of service, and purpose.	Documentation of medical transportation services provided in clients' records signed and dated.
2) Track and document referral sources in the client record.	Documentation of referral in the client record.
3) Provide cancellation policy to client, including inclement weather, breakdowns, etc.	Documentation that clients are aware of the cancellation policy.
4) Arrange cab or van transportation for clients with acute medical needs.	Documentation of cab or van transportation arrangements for clients with acute medical needs.
5) Medical transportation services provided are used solely to enable client to access HIV-related core health and support services.	Documentation of purpose for all transportation services provided (e.g., transportation to/from what type of medical or support service appointment) in client's record.
Assessment/Service Plan/Provision of Services	
6) Complete an initial assessment documenting transportation needs prior to initiation of service. A reassessment is performed with the client by the appropriate provider at the frequency established in the care plan.	Documentation of transportation need in client's record signed and dated.
7) Within fifteen (15) business days after the initial assessment a service plan will be developed and agreed upon by the client and provider, outlining service goals, objectives, and interventions. This should include client-identified needs as well as plans for continuity of primary medical care and support services, clients are assessed for: • History of accessing primary care and other services and barriers to access, particularly transportation barriers. • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation of service plan in client's record signed and dated.

Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs. Review and revise clients' needs and service plan a minimum of every six months.	
8) <u>Voucher/Token/Bus Pass System</u> Agency will have: a) Procedures in place regarding allowable uses and distribution of vouchers, bus passes, and tokens b) A tracking system in place to account for the purchase and distribution of vouchers, tokens, and bus passes c) A security system in place for storage of and access to vouchers, bus passes, and fees collected.	Documentation of each transportation service provided, signed and dated. Documentation that bus tickets/passes or gas vouchers are issued by the Ryan White Part B case manager or by designated staff.
9) Notify clients of transportation cancellations in a timely manner. Alternative transportation services will be provided as available.	Documentation of cancellation and referral to alternative transportation source in client's record signed and dated.
10) Transportation agency will be notified by client and/or provider of transportation cancellations and changes in scheduling as they occur.	Documentation of changes and cancellations in client's record signed and dated.
11) <u>Direct Transportation – Providers of Transportation Services</u> Direct Transportation Providers deliver non-emergency transportation services that enable an eligible client to access or be retained in core medical and support services. Clients are provided with information on transportation services and instructions on how to access the services. General transportation procedures: • Agency must allow clients to confirm core or support service appointments at least 48 hours in advance	A signed statement from client consenting to transportation services and agreeing to safe and proper conduct in the vehicle is on file. Documentation of client orientation to direct transportation services in client's record.

• Agency provides clients with information on transportation limitations, clients' responsibilities for accessing and receiving transportation, and the agency's role and responsibilities for providing transportation services • Clients initiate and coordinate their own services with transportation providers following client orientation to the agencies transportation policies, procedures, and client guidelines • Advocates (e.g., case manager) for the client may assist clients in accessing transportation services if needed • All clients will be screened for other transportation resources (e.g., Medicaid-eligible clients) • Accommodations are provided for related/affected individuals and/or caregivers as necessary for the benefit of the client • Client consent to transportation services and agreeing to safe and proper conduct in the vehicle is on file in the client record. Consent includes the consequences of violating the agreement, e.g., such as removal, suspension and/or possible termination of transportation services • Agency/Driver may refuse service to any client with open sores/wounds where blood and other body fluids from clients are potentially infectious. Driver to notify the agency immediately relative to any driver refusal to provide services • Clients and agencies are made aware of problems immediately (e.g., vehicle breakdown) and notification documented • Notify clients and Ryan White/State Services providers of service delays and changes to appointments or schedules as they occur.	

12) Agency must document the mileage between Trip Origin and Trip Destination (e.g., where client is transported to access eligible service) per a standard Internet-based mapping program (e.g., Yahoo Maps, Map Quest, Google Maps) or odometer reading for all clients receiving van-based transportation. Documentation of each transportation transaction includes: a) Client eligibility b) Type of transportation service used to meet client's need c) The level of service (e.g., the number of trips, tokens, passes provided to the client) d) Reason for each trip in relation to supporting health and support services e) Trip origin and destination f) Cost per trip.	Documentation of each transportation transaction in client's record signed and dated.
13) <u>Volunteer Drivers</u> Volunteer Drivers provide non-emergency transportation services that enable an eligible client to access or be retained in core medical and support services.	Documentation of each transportation transaction in client's record signed and dated.
14) <u>Purchase or Lease of Agency Vehicles</u> Proof of prior approval from HRSA/HAB/VDH to lease or purchase a vehicle. Purchased or leased vehicles provide nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.	HRSA/HAB prior approval for vehicle purchase on file at Part B recipient agency. Documentation of each transportation transaction in client's record signed and dated.
<u>Personnel Qualifications (including licensure)</u>	
Standard	**Measure**
1) All professional drivers must have a current Virginia Driver License or Virginia Commercial Driver's License (CDL) if needed and be insured.	Copy of current Virginia Driver License/Virginia Commercial Driver license and insurance coverage in driver's personnel file.

2) <u>Direct Transportation</u> Agency staff and volunteers providing medical transportation through direct transportation must maintain appropriate vehicle insurance, liability, licenses, and training as follows: a) Agency maintains correct level of liability insurance for all drivers as required by the Commonwealth of Virginia b) All drivers have current Virginia driver's licenses appropriate for the type of vehicle driven. c) Drivers must have verified driving records, receive a drug screen and background check. d) Driver has maintained a clean driving record for the past year with less than 3 convicted traffic moving violations and no DUI offenses. e) Staff and Drivers for agency conveyance will have received training in universal precautions and infection control appropriate to their duties.	Signed statement agreeing to maintain confidentiality and safe driving practices in driver's personnel file. Individual/transportation agency vehicle insurance on file with agency providing transportation services. Documentation of training completed in personnel file at agency providing transportation services.
3) Newly employed professional drivers must complete the following training within 30 days of hire: • Agency orientation • Confidentiality, client's rights, grievance procedures & sensitivity • CPR and First Aid	Documentation of training completed in personnel file.
4) All professional drivers must maintain a safe driving record and maintain current certification for CPR and First Aid.	Documentation of annual assessment of driving record and annual training in the personnel file.
5) All professional drivers must complete 2 hours of annual OSHA training on seatbelt, restraint and wheelchair safety annually.	Documentation of training completed in personnel file.
6) <u>Staff Supervision</u> a) Each agency must have and implement a written plan for supervision of all staff b) Supervisors must review monthly transportation logs for completeness,	Documentation of completed staff supervision plan at agencies providing transportation services. Documentation of monthly transportation log at agencies providing transportation services.

compliance with these standards, and quality and timeliness of service delivery c) Staff must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Documentation of annual staff performance evaluations.
<u>Quality Management</u>	
Standard	**Measure**
Measure and report client health outcomes using Medical Transportation Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people living with HIV and receiving Transportation Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Transportation Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

NON-MEDICAL CASE MANAGEMENT SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

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

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

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

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following: National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal Part A and B

For further details, the RWHAP B Service Standards, including Case Management Standards, are located at: VIRGINIA RYAN WHITE PART B PROGRAM QUALITY STANDARDS.

OTHER PROFESSIONAL SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Such services may include:

1) **Legal services** provided to and/or on behalf of the HRSA RWHAP-eligible PWH and involving legal matters related to or arising from their HIV disease, including:
    a. Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    b. Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP.
    c. Preparation of:
        i. Healthcare power of attorney
        ii. Durable powers of attorney
        iii. Living wills
2) **Permanency planning to help clients/families** make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    a. Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    b. Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.
3) **Income tax preparation services** to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance:
Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

Virginia Ryan White Part B Service Unit Definition:

One encounter with provider (virtual or in-person) per day per other professional service practice for an uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Service provider is authorized by the Internal Revenue Service (IRS) to provide federal tax preparation services.	Copy of IRS agreement/certificate on file at service provider
2) Funding for Legal Services provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status. Excludes: • Criminal defense • Class-action suits unrelated to services eligible for funding under the Ryan White HIV/AIDS Program	Documentation that funds are used only for allowable legal services. Assurance that program activities do not include any criminal defense or class action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program
3) Services offered to the client/client's family are individualized. • Healthcare power of attorney • Durable powers of attorney • Living wills	Documentation of services offered is present in the client's chart. Copy of a retainer agreement with client is present in the client's record, signed and dated.
4) All information provided by the client is confidential. It will not be released to anyone without client permission except as permitted or required by law.	Written retainer includes confidentiality assurances and is present in the client's record, signed and dated.
5) Collaboration occurs between the client and staff to decide strategies of representation, to make decisions relevant to the case and to establish goals that are achieved in a timely manner.	Documentation of the collaboration, involvement in the decision-making, and that goals are achieved in a timely manner are present in the client's record, signed and dated. Progress notes should include documentation that a copy of the service plan was provided to the client.
6) Legal services utilize management practices that are generally accepted within the legal profession.	Documentation of plan and rationale is present in the client's chart signed and dated.
7) Legal services will be supervised to ensure that services are delivered appropriately and a timely.	Documentation of the regular case review meetings, including date, people in attendance, and agenda of the meeting, will be made available for review.
8) Legal service providers make appropriate referrals when necessary.	Documentation of referral and follow-up/outcome is present in client's record, signed and dated.

Provision of Services	
9) Client Intake/application • Agency shall have an intake or application process that includes assessment of legal needs and medical care status • Client must be screened for duplication of services. • Client information is collected to facilitate referrals and follow-up as necessary.	Intake or application included in the individual client file.
10) Referrals • Client is informed of other services available in the RWHAP Part B and what client can expect if they enroll in services	Documentation in program and client files
11) Additional Programmatic Standards • Clients are kept informed of status of legal services, including upon case closure.	Consent for legal service in client file; case notes and file reflect communication and conclusion of legal services.
12) Services are provided in accordance with National Monitoring Standards to conduct appropriate action on behalf of clients to meet their legal needs. Service Agreements will be developed and signed by both the attorney and the client. Clients will be kept informed and work together with staff to determine the objective(s) of the representation. Agency may provide but not limited to the following types of legal representation, assistance, and education: • HIV discrimination in insurance, housing, employment, etc. • Assistance to immigrants with accessing and maintaining primary health care and other support services • Access to and maintenance of public benefits and entitlements • Preparation of powers of attorney • Preparation of Do Not Resuscitate (DNR) Orders • Representing clients in court and administrative proceedings where appropriate • Eviction prevention	Attorneys will document the following in the client's record: • A description of how the legal service is necessitated by the individual's HIV status • Types of services provided • Hours spent in the provision of such services.

• Employment rights counseling • Assistance with bankruptcy proceedings • Social Security benefits • Health insurance coverage • Other relevant legal advice and counseling • Referrals to other providers/programs • Referrals to pro bono attorneys • Provision of social service counseling or legal counsel regarding preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.	
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All attorneys (both staff and volunteer) meet the requirements for licensure in the Commonwealth of Virginia and are in good standing with the State Bar of Virginia.	A copy of the attorney's current license is available for review.
2) All staff and volunteer paraprofessionals and notaries possess and maintain licenses, and/or certifications as required by the Commonwealth of Virginia.	Copies of staff and volunteer paraprofessionals and notaries licenses and/or certifications are available for review.
3) Staff members are trained in, and knowledgeable of, current law and have awareness of HIV/AIDS related issues and concerns.	Documentation that staff has access to updated HIV/AIDS information is available for review.
4) All professional and paraprofessional staff must complete 2 hours of continuing education in HIV/AIDS annually.	Documentation of completion of the continuing education must be kept in the personnel files and is available for review.
5) Staff and volunteer attorneys will be licensed in the Commonwealth of Virginia. Paralegal staff or other employees must be qualified to hold the position in which they are employed. **Non-licensed staff must be supervised by a licensed attorney**.	All licensed agency professional staff, contractors, and consultants who provide legal services shall be currently licensed by the Commonwealth of Virginia. A qualified licensed attorney will supervise Law students, law school graduates and other legal professionals.

6) Staff members are trained, knowledgeable and remain current in legal issues in accordance with the rules of the Commonwealth of Virginia. Staff will attend and has continued access to training activities: • Agency paid legal staff and contractors must complete two (2) hours of HIV-specific training annually • New agency paid legal staff and contractors must complete two (2) hours of HIV-specific training within 90 days of start date • Volunteer legal staffs are encouraged to complete HIV-specific legal training. Staff providing services funded by Ryan White/State Services shall maintain knowledge of legal issues that may affect the legal assistance needs of persons with HIV/AIDS	Documentation of training on current applicable laws related to HIV infection located in personnel file. • Agency maintains system for dissemination of HIV/AIDS information relevant to the legal assistance needs of PWH to staff and volunteers • Agency will document provision of in-service education to staff regarding current treatment methodologies and promising practices.
7) A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the state of Kentucky. Training should include but not limited to: • Available HIV/AIDS services in the region and the state. • How to access such services, especially Ryan White Part B funded services. • Ryan White Service Standards (Universal and Service Category Standards)	Personnel file reflects the completion of orientation and signed job description.
8) Other professionals must the certified to perform the service required. For tax preparation, the individual should be a licensed Certified Public Accountant, a Tax attorney, or a Registered Tax Return Preparer with an IRS Tax Preparer certificate.	Professional contract or personnel file.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Other Professional Services measures approved by VDH.	Performance measurement data on the following indicators:

	• Percentage of people with HIV and receiving Other Professional Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Transportation Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

OUTREACH SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

The Outreach Services category has as its principal purpose identifying people with HIV (PWH) who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of PWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:

1) Use data to target populations and places that have a high probability of reaching PWH who

    a. have never been tested and are undiagnosed,
    b. have been tested, diagnosed as HIV positive, but have not received their test results, or
    c. have been tested, know their HIV positive status, but are not in medical care.

2) Be conducted at times and in places where there is a high probability that PWH will be identified; and
3) Be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV, or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, link eligible clients to HRSA RWHAP services.

Program Guidance:
Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care. Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Virginia Ryan White Part B Service Unit Definition:
A 15-minute face-to-face outreach visit.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Provision of all outreach services are: a) Planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort. b) Targeted to populations known to be at disproportionate risk for HIV c) Targeted to communities whose residents have a disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors. *Note:* Funds may not be used to: • Pay for HIV counseling or testing, unless no other funds are available. • Support broad-scope awareness activities that targets the public rather than specific populations and/or communities with high rates of HIV infection; or • Duplicate HIV prevention outreach efforts.	Client files must have: a) Documentation of planned outreach services and implementation to target specific populations in conjunction with local programs and are not used for disallowed services. b) Documentation of reasons for selecting targeted areas. *Note*: There is no duplication with HIV prevention efforts.
2) Document provisions of all outreach services by number of individuals reached, referred for testing, found to be positive, referred to care and entering care.	Documentation of outreach services provided and outcome from referral.

Assessment/Service Plan/Provision of Services	
3) Conduct outreach services to identify individuals who: a) Do not know their HIV status and refer them for counseling and testing; or b) Identify individuals who know their status and are not in care and help them enter or re-enter HIV-related medical care.	Documentation of individuals reached, referred for testing, referred to care or re-entered care.
4) Conduct outreach services at times and in places where there is a high probability that people with HIV will be reached.	Documentation of individuals reached, referred for testing, referred to care or re-entered care.
5) Outreach materials are tailored to target populations such as language, literacy level, culture, gender, risk factors, etc.	Documentation of materials individualized to specific populations.
6) Refer contacts to early intervention programs or other designated intake sites.	Documentation of clients referred to early intervention programs or other designated intake sites.
7) Memorandums of Agreement/Understanding will be developed to facilitate collaboration with service providers when outreach contacts may be referred. Outreach staff should be familiar with available resources in the communities.	Memorandums of agreement/understanding on file. List of resources available for review.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Outreach staff must have a high school diploma or GED or one year of experience working with patients infected with HIV or any additional health care training.	Documentation of qualifications in personnel file.
2) Newly employed outreach staff must complete the following training within 180 calendar days of hire: • HIV 101 • Outreach and procedures including safety of staff (sign out with supervisor, travel in pairs of 2; etc.,) • Infection control/blood borne pathogens • Confidentiality • Cultural competency	Documentation of training completed in personnel file.

• How to make a referral • Adherence	
3) Outreach staff must complete 6 hours of continuing education on HIV/AIDS annually.	Documentation of training completed in personnel file.
4) Non-professional staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health or a professional with equivalent experience.	Documentation of supervision in staff according to agency policy.
Quality Management	
Standard	**Measure**
1) Measure and report client health outcomes using Outreach Services service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people living with HIV and receiving Outreach Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program living with HIV and receiving Outreach Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

PSYCHOSOCIAL SUPPORT SERVICE STANDARDS

Description from Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PWH to address behavioral and physical health concerns.

Activities provided under the Psychosocial Support Services may include:

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

Program Guidance:
May not use funds under this service category to provide nutritional supplements (*See* Food Bank/Home Delivered Meals)

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

May not use HRSA RWHAP funds for social/recreational activities or to pay for a client's gym membership.

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

Record service utilization for conducting Ryan White Part B Unified Eligibility Assessments for an individual not case managed under **Psychosocial Support Services.**

Virginia Ryan White Part B Service Unit Definition:
One 15-minute individual or group Psychosocial Support session (**or**) one 15-minute increment of Unified Eligibility Assessment assistance for clients who are not case managed/receiving case management services.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Document provision of all Psychosocial Support Services by type and level of activities.	Documentation of Psychosocial Support Services conducted by type and level of activities signed by provider of support services.
2) When a third-party payer provides service, the subrecipient must maintain a client record. At a minimum, the payer's record must contain: • Referral • Initial assessment • Individualized treatment plan • Documentation of all contacts & dates of service • Reassessment of treatment plan • Referrals and follow-ups • Discharge plan. Must sign and date all reports.	Documentation of provided services, signed, and dated records.
Assessment/Service Plan/Provision of Services	
3) An initial psychosocial assessment of client's needs to be completed prior to the initiation of the service plan.	Documentation of assessment in client's record signed and dated by the counselor.
4) Within fifteen (15) business days after the initial assessment a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services, clients are assessed for: • Support system and psychosocial support needs • History of accessing primary care and other services and barriers to access, noting psychosocial support barriers. Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs.	Documentation of service plan in client's record, signed and dated by the staff. In addition, review and revise client needs and service plan a minimum of every six months.

5) Counseling Services Staff may provide counseling related to: • Child abuse and neglect counseling • Bereavement counseling • Nutrition counseling (provided by non-registered dietitian) Psychosocial Support staff will make appropriate referrals.	Documentation of Psychosocial Support Services conducted by type and level of activities signed by provider of support services.
6) Support Groups HIV support groups include, but are not limited to, caregiver and HIV support. Staff or volunteers providing psychosocial support through group facilitation will include discussions on: • Treatment adherence • Access and engagement in primary care • Access and engagement in case management, if appropriate.	Evidence of client progress toward meeting established goals through documentation of activity including sign-in sheets, progress notes, group curricula, etc.
7) Virginia Ryan White Part B Eligibility (non-case managed clients) Staff will conduct Virginia Ryan White Part B Eligibility for non-case managed clients. Record eligibility assessments for non-case managed clients as a Psychosocial Support Service.	Documentation of eligibility assessment submitted in the Provide Enterprise® data system.
8) Reassess service plan every 6 months to assess progress and identify emerging needs.	Documentation of review and update of the plan as appropriate, signed and dated by staff. Progress notes should include documentation that a copy of the service plan was provided to the client.
9) Refer client to other services as appropriate, e.g., mental health, substance use disorder treatment.	Documentation of referrals made and status of outcome in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All psychosocial and pastoral care counselors will have appropriate and valid	Copy of current licensure in personnel file.

licensure if required by the Commonwealth of Virginia.	
2) All staff who deliver non-professional counseling services or group facilitation must have a high school diploma or General Equivalency Diploma (GED) and one year of experience working with people with HIV, providing counseling services or additional health care training.	Documentation of qualifications in personnel file.
3) Newly employed psychosocial counselors, including individual practitioners, must complete orientation within 2 weeks of hire and the following training within 180 days of hire: • HIV 101. • HIV testing (through VHARCC). • Cultural competency. • Legal ramifications, including confidentiality. • Counseling & referral; and • Prevention (through VHARCC).	Documentation of training completed in personnel file.
4) All staff and volunteers providing will be trained in the following core competencies: • Active listening and other one-on-one support skills • Group facilitation (if applicable) • Conflict de-escalation/resolution • Roles and responsibilities of peer emotional support and the difference between this service and other services • Client eligibility assessment skills • HIV co-morbidities, symptoms, medications, interactions and side effects. Train program staff in conducting nutritional counseling to perform nutritional assessments.	Documentation of training completed in personnel file.
4) All psychosocial counselors must complete 6 hours of continuing education in counseling or HIV/AIDS annually.	Documentation of continuing education credits in personnel file.
6) Required supervision of all non-professional staff delivering psychosocial support services by a licensed professional.	Documentation of supervision according to agency policy.

Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Psychosocial Support Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people with HIV and receiving Outpatient Ambulatory Health Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Psychosocial Support Services, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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REFERRAL FOR HEALTH CARE AND SUPPORT SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other types of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Virginia Ryan White Part B Service Unit Definition:
One 15-minute encounter.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities

Standard	Measure
1) Screening and intake to be completed within 5 days of initial contact with patient.	Documentation of intake, eligibility screening & needs assessment in patient's record.
2) Referral services are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services.	Documentation of referral services conducted by date of service, type of communication, referral & follow up provided.
3) Refer persons who are HIV-positive to medical care within 5 days of intake.	Documentation with date of persons referred for medical care and/or patient's refusal.
4) Determine if referred patients have engaged in medical care within 1 month of referral.	Documentation of medical visit attendance in patient's record.
5) Refer persons who are HIV-positive to appropriate supportive services within 14 days of intake.	Documentation with date and referral information of persons referred for supportive services and/or patient's refusal.
6) Determine if referred patients completed the referral within 1 month of referral.	Documentation of outcome of referral in patient's record.

7) Conduct a reassessment every 90 days to determine additional and/or ongoing needs.	Documentation of reassessment every 90 days in patient's record.
8) Referral for Health Care services, according to HRSA National Monitoring Standards, develop and implement services to direct clients to needed services. Referral services will: • Direct a client to a service in person or through other types of communication • Possible modes of communication include telephone, phone, email, and/or text messages • Client must specify which mode(s) of communication is acceptable • Staff must maintain client confidentially in all communications • Provide benefits/entitlements counseling and referral	Documentation of implemented services that directed clients to needed services in patient's record. Documentation of specified mode of communication by client in patient's record.
Assessment/Provision of Services	
9) Staff will conduct an intake within five (5) business days of initial contact with the client to determine eligibility for and need of health care or supportive service referral services.	Documentation with date of intake, eligibility screening & identification of needs
10) For Services Benefits Counseling: a) Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. b) It is the primary responsibility of staff to ensure clients are receiving all the benefits/resources for which they are eligible. c) Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with recertifications,	Documentation of progress of client enrollment into eligible benefits/resources for which they are eligible for and located in client's file. Documentation of completed follow-up after 90-days to assess if additional needs or benefits are needed and placed in client's record.

and provide advocacy in other areas relevant to maintaining benefits/resources d) Staff will explore the following as possible options for clients: • AIDS Drug Assistance Program (ADAP) • Health Insurance Premium Payment • Food stamps • Insurance Continuation (COBRA, OBRA, HIPAA) • Medicaid • Medicare • Pharmaceutical Patient Assistance Programs (PAPS) • Private Insurance • Health Insurance through Affordable Care Act (ACA) • Social Security Programs • Social Security Disability Insurance (SSDI) • Supplemental Security Income (SSI) • Social Security Retirement State Disability Insurance (SDI) • Temporary Aid to Needy Families (TANF) • Unemployment Insurance (UI) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Worker's Compensation • Other public/private benefits programs. e) Assist clients who are HIV positive with completion of benefits application as appropriate within fourteen (14) business days of referral intake f) Determine if referred patients completed the application process within 30 business days of referral	

g) Conduct a follow-up within 30 and 90 days of completed application to determine if additional and/or ongoing needs are present	
11) Staff will assist clients in accessing available resources for health care entry into and movement through care service systems: • Refer persons who are HIV positive to medical care within five (5) business days of referral intake • Determine if referred patients have engaged in medical care within 30 business days of referral • Refer persons who are HIV positive to appropriate supportive services within fourteen (14) business days of referral intake • Determine if referred patients completed the referral within 30 business days of referral.	Documentation of referral made to medical care in client's record.
12) Staff will follow-up on referrals to determine whether the client accessed medical care and/or other services to ensure that they continue receiving said services and to avoid duplication and to prevent client abuse of the care system.	Documentation of referral follow-up in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Referral staff must have a high school diploma or GED and one year of experience working with patients infected with HIV or additional health care training.	Documentation of qualifications in personnel file.
2) Newly employed referral staff must complete the following training within 180 calendar days of hire: • HIV 101 • Cultural competency • Counseling and Referral.	Documentation of training completed in personnel file.
3) Referral staff must complete six (6) hours of continuing education on HIV/AIDS annually.	Documentation of continuing education credits in personnel file.

4) Staff should be knowledgeable and experienced regarding referral services and the HIV Continuum of Care. Staff and volunteers who provide referral services shall possess the following: • Knowledge about and experience working with underserved populations • Knowledge of and ability to effectively utilize interviewing, assessment and presentation skills and techniques in working with a wide variety of people • Knowledge of community resources available to eligible persons so that appropriate effective referrals can be made • Skills and experience necessary to work with a variety of HIV/AIDS service providers, including other referral staff, case managers and interdisciplinary personnel and directs who are culturally and linguistically diverse.	Documentation reflecting knowledge and skills in the staff personnel file.
5) Within the first three (3) months of hire, training for new staff and volunteers shall include but not limited to: • Specific HIV-related issues • Substance abuse and treatment • Mental health issues • Domestic violence • Sexually transmitted diseases • Partner notification • Housing Services • Adolescent health issues • Commercial sex workers • Incarcerated/recently released • Gay/lesbian/bisexual/trans-gender concerns. b) Continuum of care for HIV+ persons including the process of referring a client to a medical intake site • Safety protocols for staff and volunteers governing the way	Documentation of training completed in personnel file.

referral services will be provided • Staff has knowledge of local resources. c) Ongoing training for staff must be provided to appropriate staff to maintain current knowledge about outreach, including information about advances in medical care and treatment of PWH. d) Personnel records will reflect completion of training.	
6) All non-professional staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health or possess equivalent experience. • Supervisors must review a sample of ten percent (10%) of each staff member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. • Each supervisor must maintain a file on each staff member supervised and hold supervisory sessions at least monthly.	Results of the supervisory review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.

Quality Management	
Standard	**Measure**
Measure and report client health outcomes using referral for Health Care/Supportive Services measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of people enrolled in RWHAP Part B-funded Program with HIV regardless of age and receiving Health Care/Supportive Services, who will have at least one care markers in a 30-day period. • Percentage of persons with HIV and receiving referral for Health Care/Supportive Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-

	month period that are at least 3 months apart.

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REHABILITATION SERVICE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Rehabilitation Services provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Program Guidance: Allowable activities under this category include physical, occupational, speech, and vocational therapy. Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Virginia Ryan White Part B Service Unit Definition:
One rehabilitation service session provided per day for uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Comprehensive Assessment: Provider will complete a comprehensive assessment within five (5) business days of the referral to include: • Presenting issue • Physical examination and evaluation performed by the therapist relevant to the type of therapy prescribed • Diagnosis • Prognosis	Documented evidence of client's comprehensive assessment in the client's primary record of a completed comprehensive assessment within five (5) business days of referral.
2) Plan of Care: In collaboration with the client a plan of care will be developed within ten (10) business days of the completed comprehensive assessment. The plan of care should be signed and dated by the client and located in the client's primary record. A copy of the plan will be offered to the client and documented in the client's record. The plan of care should include: • Objective for rehabilitative services	Documented evidence in the client's primary record of a plan of care developed within ten (10) business days of the completed comprehensive assessment.

• Estimated number of sessions • Type of therapy • Estimated duration. Documentation that plans of care is being followed will include date therapy received, therapy performed, and progress toward meeting objectives in the client's primary record. Plan of care must be reviewed not less than every six (6) months to determine if progress is being met towards meeting objective with documentation in the client's primary record.	
3) Referrals: If the needs of the client are beyond the scope of the services provided by the agency/provider, an appropriate referral to another level of care is made. Documentation of referral and outcome of the referral is present in the client's primary record.	Documented evidence in the client's primary record of referrals, as applicable, for services necessary.
4) Client's progress is assessed and monitored regularly, and a treatment plan is developed and signed by the professional rendering the services.	Progress notes on file
5) Services are not provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable	
Personnel Qualifications (including licensure)	
Standard	**Measure**
Providers and facilities providing services have appropriate and valid licenses, certifications, and/or registrations as required under applicable federal, state, and local laws.	Documentation on file
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Rehabilitation Service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of clients with documented evidence in the client's primary record of a plan of care developed within ten (10) business days of the completed comprehensive assessment. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Health Insurance

	Premium and Cost Sharing Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

RESPITE CARE STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-today care.

Program Guidance: Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities. Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted. Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership. See also Psychosocial Support Services

Virginia Ryan White Part B Service Unit Definition:
One respite care service provided per day for uninsured client.

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Initial Brief Assessment: Agency staff will initiate an intake within five (5) business days of the referral to include: • Client's support system. • Needs of the client. Supporting documentation of the need for respite care will be included in the assessment. If informal respite care is to be used, assessment must include qualifications of the client's personal support network provider.	Percentage of clients with documented evidence of an initial brief assessment completed within five (5) business days of the referral in the client's primary record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) Providers and facilities providing services have appropriate and valid licenses, certifications, and/or registrations as required under applicable federal, state, and local laws.	Copy of qualifications in employee personnel file.

2) Recreational and social activities are provided in a licensed or certified provider setting, including drop-in centers within HIV Outpatient Ambulatory Health Services or satellite facilities	Documentation on file
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Respite Care Service measures approved by VDH.	Performance measurement data on the following indicators: • Percentage of clients with documented evidence of an initial brief assessment completed within five (5) business days of the referral in the client's primary record. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Health Insurance Premium and Cost Sharing Assistance, regardless of age, who will have an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the Service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

SUBSTANCE ABUSE SERVICES (RESIDENTIAL) STANDARDS

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02, Eligible Individuals & Allowable Uses of Funds: HRSA's Policy Clarification Notice # 16-02

Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include:

- 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)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the HRSA RWHAP.

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

RWHAP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

Virginia Ryan White Part B Service Unit Definition:
30 days or less residential substance abuse service = one unit.

(Residential treatment program must comply with HAB PCN #16-02 Substance Abuse Services - Residential definition and program guidance.)

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for people with HIV, including the following:

Key Services Components and Activities	
Standard	**Measure**
1) Services to be provided by or under the supervision of a physician, or other qualified personnel, with appropriate and valid licensure and certification by the State in which the services are provided.	Documentation available of provider licensure or certifications as required by the State in which service is provided. Provide assurance that all services are provided in a short-term residential setting.
2) Services to be provided in accordance with a treatment plan.	Maintain program files that document: • That all services provided are allowable under this service category • The quantity, frequency, and modality of treatment services.
3) Detoxification to be provided in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of a hospital).	Services are provided in accordance with a written treatment plan. Maintain client records that document: • The date treatment begins and ends • Individual treatment plan • Evidence of regular monitoring and assessment of client progress. Assurance that services are provided only in a short-term residential setting.
Assessment/Service Plan/Provision of Services	
4) An initial substance abuse assessment of client's needs to be completed within 10 days of initial contact with client and prior to the initiation of the service plan. Assessment to include: • Substance use history and status • Medical history and current health status • Availability of food, shelter, transportation, financial resources • Support system • Legal issues/custody status • Mental health status and co-existing conditions.	Documentation of assessment available in client's record signed and dated.
5) If substance abuse serves are deemed appropriate, a substance abuse treatment plan is developed within 30 days of the initial assessment to include: • Diagnosed condition	Documentation of treatment plan in client's record signed and dated.

• Treatment modality (individual or group) • Treatment goals • Start date for services • Projected end date for services • Recommended number of sessions • Reassessment dates of client progress. *Note:* Substance abuse services must be provided by or under the supervision of a physician or other qualified/licensed provider.	
6) A complete psychosocial assessment will be completed. Results of the assessment will be used to complete the treatment plan as necessary.	Documentation of complete psychosocial assessment in client's record signed and dated.
7) Service plan is reassessed every 90 days for progress and to identify emerging needs.	Documentation of review and update of the plan, as appropriate, signed and dated by staff. Progress notes should include documentation that a copy of the service plan was provided to the client.
8) Substance abuse services, provided as group or individual sessions, should be specific to individual client needs. Progress notes should be completed for every counseling session and include: • Session date and duration • Focus of session and observations • Assessment and interventions • Newly identified issues/goals • Client's responses to interventions and referrals.	Documentation of mental health services provided in client's record signed and dated.
9) Treatment options shall be a joint decision between the client and provider and should address the full spectrum of substance use. Services are limited to the following: • Pre-treatment/recovery readiness programs • Harm reduction • Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse • Outpatient drug-free treatment and counseling	Documentation of treatment modalities employed in client's record signed and dated. If provided, referral for acupuncture services in client's record signed and dated.

• Opiate Assisted Therapy • Neuro-psychiatric pharmaceutical • Relapse prevention • Limited acupuncture services. *Note:* For any client receiving acupuncture services, a written referral from the primary care provider must be in the client file.	
10) Treatment plan is reviewed at least every 12 sessions and modified as appropriate.	Documentation of review and update of treatment plan as appropriate signed and dated.
11) Refer client to other medical, mental health and other services as appropriate, e.g., psychiatric services, mental health services, in-patient hospitalization, case management.	Documentation of referrals made and status of outcome in client's record.
Personnel Qualifications (including licensure)	
Standard	**Measure**
1) All substance abuse (outpatient) service providers and substance abuse counselors will have appropriate and valid licensure/certification as required by the Commonwealth of Virginia.	Copy of current licensure and/or certification in personnel file.
2) Newly employed substance abuse professionals must complete orientation within 90 days of hire and training included but not limited on: • Hepatitis B and C • Sexually Transmitted Diseases • Tuberculosis • Referral for crisis intervention policy/procedures • Confidentiality • Emergency and safety procedures • Cultural competency	Documentation available of training completed in personnel file.
3) All substance abuse professionals must complete 2 hours of continuing education in HIV/AIDS treatment or care annually.	Documentation of training complete in personnel file
4) A substance use disorder treatment supervisor shall be a Certified Clinical Supervisor.	Documentation of certification in personnel file.

5) A written policy regarding regular supervision of all licensed staff will be in place.	Documentation of supervision according to agency policy.
6) The provider agency must be a licensed facility with outpatient substance use treatment designation and must comply with the rules and standards established by DBHDS.	Agency will have documentation on site that license is current for the physical location of the treatment facility.
Quality Management	
Standard	**Measure**
Measure and report client health outcomes using Substance Abuse Services approved by VDH.	Performance measurement data on the following indicators: • Percentage of persons with HIV and receiving Substance Abuse Services, regardless of age, with at least two Ryan White Part B service encounters in a 12-month period that are at least 3 months apart. • Percentage of people enrolled in RWHAP Part B-funded Program with HIV and receiving Substance Abuse Services, regardless of age, who will have an HIV viral load lesser than 200 copies/mL at last HIV viral load test during the measurement year.

DISCLAIMER: Ryan White Eligibility for the service, Personnel, Client Transition, Discharge, Case Closure, Client Rights and Responsibilities, Grievance Process, Cultural and Linguistic Competence, and Privacy and Confidentiality are included in the Universal Standards.

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