MARION COUNTY PUBLIC HEALTH DEPARTMENT
RYAN WHITE
HIV SERVICES PROGRAM

PART A/MAI AND PART C ● STANDARDS OF CARE FOR HIV SERVICES

REVISIONS

APPROVALS
All approvals are maintained and controlled by the Ryan White Part A HIV Services Program.

REVISIONS
This document may be revised or updated periodically. The table below shows the history of such revisions. Draft and archived revisions are not to be used.

AUTHOR	REVISED SECTION	REVISION #	RELEASED
Systems of Care Committee	Initial Release	01	5 May 2011
Systems of Care Committee	Added Introduction page notes; Made general editorial revisions and corrections throughout	02	15 August 2013
Systems of Care Committee with TSC Consulting , LLC	Added 13 additional service categories; Added Table of Contents; Added Abbreviations section; Made general editorial revisions and corrections throughout, including the addition of language from PCN #16-02 (revised version) where applicable	03	15 March 2017

EDITORIAL NOTES

This document is based largely on the following documents:[1]

- **National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal** (April 2013) https://hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf
- **National Monitoring Standards for Ryan White Part A Grantees: Program** (April 2013) https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- **Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds Policy Clarification Notice #16-02** (Revised December 2016) https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

Additionally, portions of this document were originally developed by reviewing and revising materials developed by the New York State Department of Health prior to 2010.

National Monitoring Standards language has been incorporated into this document in the following manner:

- Verbiage from the Monitoring Standards' "Standard" column for each service category was used to inform the definition for each service in this document (in general, this verbiage does not re-appear in this document's *Standard/Measures* tables);
- Verbiage from the Monitoring Standards' "Performance Measure/Method" column was used to inform the language in the "Standard" column of this document's *Standard/Measures* tables;
- Verbiage from the Monitoring Standards' "Grantee Responsibility" column, generally, does not appear in this document; and
- Verbiage from the Monitoring Standards' "Provider/Subgrantee Responsibility" column was used, in part, to inform the language in the "Measures" column of this document's *Standard/Measures* tables, as applicable.

While the National Monitoring Standards do not necessarily apply to Part C funding, these standards are applied to all RWSP activities, including those fully or partially supported by Part C funds.

[1] All issued by the HIV/AIDS Bureau.

ABBREVIATIONS

ADAP	AIDS Drug Assistance Program
AACRN	Advanced HIV/AIDS Certified Registered Nurse
ADA	Americans with Disabilities Act
CDC	Centers for Disease Control and Prevention
CEU	Continuing Education Unit
CLAS	National Standards for Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendments
CPR	Cardiopulmonary Resuscitation
DHHS	Department of Health and Human Services
EFA	Emergency Financial Assistance
EIS	Early Intervention Services
FDA	Food and Drug Administration
FPL	Federal Poverty Level
HIPAA	Health Insurance Portability and Accountability
HAB	HIV/AIDS Bureau
HOPWA	Housing Opportunities for Persons With AIDS
HRSA	Health Resources and Services Administration
ISDH	Indiana State Department of Health
LPAP	Local AIDS Pharmaceutical Assistance Program
MCPHD	Marion County Public Health Department
OSHA	Occupational Safety and Health Administration
PCP	Primary Care Provider
PHS	Public Health Service
PPC	Public Passenger Chauffeur
PrEP	Pre-Exposure Prophylaxis
QM	Quality Management
RWSP	Ryan White Services Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SSDI	Social Security Disability Insurance
TGA	Indianapolis Transitional Grant Area

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PART A AND PART C ● STANDARDS OF CARE FOR HIV SERVICES

Introduction

The Universal Standards of Care presented in this document apply to all programs in the Indianapolis Transitional Grant Area (TGA) funded by the Ryan White Services Program (RWSP) administered by the Marion County Public Health Department (MCPHD) using federal Ryan White Part A and Part C funds. In addition to these universal standards, there are additional standards that apply to each of the specific service categories allowed by the Health Resources and Services Administration (HRSA). Allowable service categories include:

Core Medical Services

1. Outpatient and Ambulatory Medical Care (including laboratory tests)
2. AIDS Drug Assistance Program (ADAP)
3. Local AIDS Pharmaceutical Assistance Program (LPAP)
4. Oral Health Services
5. Early Intervention Services (EIS)
6. Health Insurance Premium and Cost-Sharing Assistance
7. Home Health Care
8. Home and Community-Based Health Services
9. Hospice Care
10. Mental Health Services
11. Medical Nutrition Therapy
12. Medical Case Management Services (including treatment adherence)
13. Substance Abuse Treatment Services – Outpatient

Support Services

14. Case Management (non-medical)
15. Child Care Services
16. Emergency Financial Assistance (EFA)
17. Food Bank and Home-Delivered Meals
18. Health Education and Risk Reduction
19. Housing Services
20. Legal Services (including permanency planning)
21. Linguistic Services
22. Medical Transportation Services
23. Outreach Services
24. Psychosocial Support Services (including pastoral care and counseling)
25. Referral to Health Care and Supportive Services
26. Rehabilitation Services
27. Respite Care
28. Substance Abuse Treatment – Residential
29. Treatment Adherence Counseling

Due to funding limitations or the existence of other available resources, some of the services listed above are not currently offered in the TGA by the RWSP.

Because it is generally limited to Ryan White Part D programs, an additional service category (Developmental Services for HIV Positive Children) is not addressed in this document.

Special Notes about Eligibility

In order to be eligible for RWSP enrollment, a person must:

- Have a confirmed HIV-positive diagnosis;
- Have a household income less than 300% of the federal poverty level; and
- Reside in one of the ten counties that comprise the Indiana TGA (i.e., Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, Putnam, or Shelby County).

It is important for all RWSP providers to understand that some clients may be provisionally approved for services and placed in "Pending" status. A pending client is a person:

- Who has indicated a current (not anticipated) residential address within the TGA;
- Who cannot produce diagnosis, income, or residency documentation that satisfies the RWSP eligibility requirements at the time of application; and
- Who has never been previously enrolled in the RWSP or whose most recent RWSP program termination date was more than two years ago.

A person may remain in pending status for seven business days. At the end of this period, the person must be able to supply the required documentation or actively request an extension. Failure to do so results in termination from the program. The RWSP, at its sole discretion, may allow up to two extensions (not to exceed a total of 21 business days). Persons who are denied extensions or who exhaust all of the approved extensions and who continue to be unable to supply the required documentation are terminated from the program. However, all covered service costs incurred during the pending period remain reimbursable.

SECTION A: Universal Standards of Care

Universal Standards of Care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by the RWSP through MCPHD. Providers may exceed these standards.

1. Agency Operations

These standards for *Agency Operations* are designed to ensure that:

1. The program location and condition ensure the physical safety, meet the physical needs, and uphold the confidentiality and personal security of all employees and clients;
2. The program observes recommended Occupational Safety and Health Administration (OSHA) and state public health practices for infection control for care of immunologically impaired individuals; and
3. Agencies demonstrate compliance with Indiana state regulations, including licensing and Health Insurance Portability and Accountability Act (HIPAA) requirements, as appropriate for the services they are funded to provide.

	STANDARD	MEASURE
1.1	The agency has all appropriate licensures and accreditations.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
1.2	The agency has a system of safeguarding client information (written, verbal, record storage) that meets HIPAA regulations.	• Written policies are current, on file, and available for review.
1.3	The agency has a system for tracking service provision that records client level data (for services that are delivered at the client-level).	• Written policies are current, on file, and available for review.
1.4	The agency has a billing system that ensures fiscal responsibility, allows for auditing, and prevents billing multiple service lines items for a single service event.	• Written policies are current, on file, and available for review.
1.5	The facility meets fire safety requirements, and is neat, clean, and free of clutter, hazardous substances, or other obstacles that could cause harm.	• Condition is confirmed during a site visit or other physical observation.
1.6	The agency is compliant with the Americans with Disabilities Act (ADA) for physical accessibility.	• Proof of ADA certification or compliance is current, on file, and available for review. • Condition is confirmed during a site visit or other physical observation.
1.7	Facility has ample seating and space to accommodate patient volume.	• Condition is confirmed during a site visit or other physical observation.

2. Agency Policies and Procedures

These standards for *Agency Policies and Procedures* are designed to ensure that:

1. Services are available to all eligible clients within the service area;
2. Agencies respect clients' autonomy, diversity, and right to confidentiality;
3. Services are appropriate and responsive to the needs of the client;
4. Agencies respond fairly to allegations of mistreatment, poor service, or wrongful discharge from the program; and
5. Clients are informed and encouraged to actively participate in the system of care.

	STANDARD	MEASURE
2.1	Services are made available in areas accessible to target population.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of stated hours of operation, location, and accessibility with public transportation.
2.2	Services are made available to residents of each county within the TGA.	• Condition is confirmed by review of applicable documentation in service records.[2]
2.3	Services are rendered only to clients who are eligible and enrolled in the RWSP.	• Condition is confirmed by review of applicable documentation in service records.
2.4	Services are rendered only to clients who are ineligible for or have exhausted other payer sources (to ensure that the RWSP remains the payer of last resort).	• Condition is confirmed by review of applicable documentation in service records.
2.5	Reimbursement is sought from the RWSP for only those services deemed allowable by the RWSP.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
2.6	Ryan White eligibility is determined on the client's first visit to the agency and an application for enrollment is completed when appropriate.	• Condition is confirmed by review of applicable documentation in service records.
2.7	All information necessary to provide client with services is ascertained at the first client visit.	• Condition is confirmed by review of applicable documentation in service records.
2.8	The agency responds to initial client contact within one working day.	• Written policies are current, on file, and available for review.
2.9	Eligible clients receive services within 14 working days of client contact; if this is not possible, the reason for the delay is documented in the client's file.	• Condition is confirmed by review of applicable documentation in service records.

[2] The term "service record" may include the client enrollment file, case notes, documentation of services provided, and the client's medical record, as applicable per service category.

2.10	Services are documented in such a manner that another provider could provide continuity of care in an emergent situation. Documentation in service records includes, at a minimum: • Staff member updating chart; • Date; • Time spent with client; • Service delivered; • Time frame for any next steps; and • How service delivered relates to client's service plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation is signed by the provider.
2.11	The agency has a written referral process for all clients needing services outside of the agency, and all referrals are documented in client's file.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
2.12	The agency ensures that each client it serves receives information regarding the agency's philosophy and treatment practices before services are rendered.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
2.13	The agency has policies in place for the following: • Client rights and responsibilities, including behavioral expectations and right to obtain no-cost interpreter services in their preferred language; • Confidentiality (and limits thereto) in accordance with state and federal laws; • Client eligibility; • Informed consent; and • Allowable response time.	• Written policies are current, on file, and available for review.
2.14	The agency ensures that clients and staff are informed of the policies that affect them.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that client rights, confidentiality, eligibility, and informed consent policies have been discussed with client. • Client rights and confidentiality policies are posted within agency in locations accessible to clients and staff.

2.15	The agency has procedures in place to govern the following: • Intake process; • Assessment of need (ensuring that clients' short and long term needs are identified, a plan is made to address them, and specific action items and deadlines are instituted to facilitate their completion); • Documentation of need; • Case closure; • Grievances; • Infection control and transmission risk management; • Managing after-hours and emergency contacts; • Providing services to clients with limited English proficiency; • Managing clients who present for services in an inebriated or disruptive state; and • Advocating for clients who are deemed incapable of making decisions due to neurological, cognitive or medical conditions associated with HIV disease.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records. – Service records reflect staff understanding and adherence to agency procedures. – Service records include documentation that case closure and grievance policies have been discussed with client. • Grievance policies are posted within agency in locations accessible to clients and staff. • Policies related to services to be provided to non-English speakers meet CLAS standards.[3]

[3] Culturally and Linguistically Appropriate Services (CLAS) standards were issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) in 2001. OMH developed these standards to ensure that all people entering the health care system receive treatment in a culturally and linguistically appropriate manner. The CLAS standards include mandates, guidelines, and recommendations. The following standards will help agencies meet the four CLAS mandates:

1. Agencies must provide to clients in their preferred language both verbal offers and written notices informing of their right to receive language assistance services.
2. Agencies must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with limited English proficiency at all points of contact, in a timely manner during all hours of operation. (Preference is first for bilingual staff, and when that option is not available face-to-fact interpretation. Telephone interpretation services should be used as a supplemental system when an interpreter is needed instantly, or when there is no interpreter available for an infrequently encountered language.)
3. Agencies must assure the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff. Families and friends should not be used to provide interpretation services (except on request of the client).
4. Agencies must make available easily understood patient-related materials and post signage in the language of commonly encountered groups or groups represented in the service area.

3. Program Staff

These standards for *Program Staff* are designed to ensure that:

1. Clients have access to the highest quality of services through experienced, trained staff;
2. Services are provided by appropriately licensed professionals with service-specific education and experience; and
3. Staff members receive the training and supervision to enable them to perform their jobs well and to provide culturally and linguistically appropriate care to HIV positive clients.

	STANDARD	MEASURE
3.1	Program staff and supervisors have current licensure, certification, and registration appropriate to their position.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is present in personnel files and available for review.
3.2	The agency conducts a criminal background check of staff and volunteers who provide direct care services.	• Written policies are current, on file, and available for review. • Documentation of criminal background checks is present in personnel files[4] and available for review.
3.3	The agency conducts an annual check for valid driver's licenses for any staff or volunteers providing transportation to clients or performing home visits or other field work.	• Documentation is present in personnel files and available for review.
3.4	The agency ensures that staff who have client contact have an annual TB test.	• Documentation is present in personnel files and available for review.
3.5	Agencies will recruit a diverse staff that reflects the cultural and linguistic diversity of the community served.	• Written policies (including recruitment strategies) are current, on file, and available for review.

[4] "Personnel" includes both employees and volunteers.

3.6	Within one month and before seeing clients, staff and volunteers (as appropriate to level and type of client contact) will be trained and knowledgeable in the following areas: • HIV disease basics (including universal precautions); • Affected communities served by agency (to ensure a clear understanding of HIV's local impact); • Job responsibilities (to ensure a clear understanding of their job description and expectations); • Legal reporting and disclosure requirements; • Documentation and record keeping standards; • Professional boundaries; • Agency policies; and • Physical safety policies.	• Documentation (including a written job description signed by both staff person and supervisor) is present in personnel files and available for review.
3.7	Within three months, staff and volunteers (as appropriate to level and type of client contact) will be trained in the following areas: • Functional knowledge of HIV issues (including epidemiologic trends, co-morbidities, basics of treatment, basic psychosocial issues, mental health, and substance use); • TB and other infectious diseases; • Crisis intervention; • Infection control; • Cultural competency; and • Continuum of care (including local resources and programs).	• Documentation is present in personnel files and available for review.
3.8	Staff and volunteers will receive training and education to build linguistic and cultural competencies (with respect to age, race, ethnicity, gender, creed, and sexual orientation) at least once per year.	• Documentation of all relevant training is present in personnel files and available for review.
3.9	Staff participate in continuing education opportunities as applicable *(refer to individual service categories for details)*.	• Documentation of all relevant training is present in personnel files and available for review.

4. Quality Improvement

These standards for *Quality Improvement* are designed to ensure that:

1. Quality improvement activities are integrated into the ongoing planning and work of both funded agencies and the RWSP;
2. Agencies monitor performance and compliance with standards of care;
3. Agencies identify critical areas for improvement and monitor changes over time to determine if improvements have been made; and
4. Agencies increase efficiency and improve quality of care.

	STANDARD	MEASURE
4.1	The agency engages in RWSP Quality Management (QM) activities.	• Condition is confirmed by review of RWSP QM meeting minutes and attendance records.
4.2	The agency tracks their outcomes in helping clients access and remain in medical care and to adhere to medications.	• Condition is confirmed by review of year end progress reports submitted by agency.
4.3	The agency has a mechanism for obtaining client feedback and satisfaction, documents its regular use, and responds to the feedback it receives.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of client feedback and agency response.
4.4	The agency will develop a program evaluation and improvement process based on the findings of RWSP QM activities and client satisfaction surveys.	• Written policies are current, on file, and available for review.
4.5	The agency uses the applicable Part A Program Monitoring Standards published by the HIV/AIDS Bureau (HAB) which fully describes the monitoring expectations for Ryan White Part A grantees and sub-grantees.	• Written policies are current, on file, and available for review.

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SECTION B: Service Specific Standards of Care
In addition to the Universal Standards of Care, providers of RWSP funded services must also meet additional standards that are specific to the service they are funded to provide.

1. Outpatient and Ambulatory Medical Care (including laboratory tests)

Outpatient and Ambulatory Medical Care is the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room and urgent care services are not considered to be outpatient settings.

Services include diagnostic testing, early intervention and risk assessment, medical history taking, physical examination, diagnosis and treatment of common physical and mental conditions, behavioral risk assessment (including subsequent counseling and referral), preventive care and screening, pediatric development assessment and well-baby care, prescribing and managing medication therapy, education and counseling on health issues, treatment adherence (provided in the context of outpatient medical care), continuing care and management of chronic conditions, referral to and provision of specialty care (including all medical subspecialties), and laboratory testing integral to the treatment of HIV infection and related complications.

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

These standards for *Outpatient and Ambulatory Medical Care* are designed to ensure that agencies:
1. Provide and coordinate high quality care for the routine needs of clients with complex medical conditions;
2. Assess and respond appropriately to the physical, psychosocial, cognitive and therapeutic needs of clients; and
3. Coordinate care with collateral service providers and systems to ensure optimal client care and provide appropriate referrals for assessment and treatment.

	STANDARD	MEASURE
1.1	Care is provided by health care professionals certified in Indiana to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.

1.2	Providers have specific experience and appropriate training in caring for HIV infected clients or access to such expertise through consultations.	• Documentation -- such as Continuing Education Units (CEUs) and Advanced HIV/AIDS Certified Registered Nurse (AACRN) certification for nurse practitioners – is present in personnel files and available for review. • Consultation relationships are documented by signed memoranda of understanding. • Condition is confirmed by review of applicable documentation in service records.
1.3	HIV medical care is consistent with current PHS guidelines.	• Condition is confirmed by review of applicable documentation in service records. • Aggregate results in comparison to HRSA's Performance Measure Portfolio, particularly the Core Measures,[5] are compiled annually and available for review.
1.4	Only allowable services are provided.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
1.5	Services are provided as part of the treatment of HIV infection.	• Condition is confirmed by review of applicable documentation in service records.
1.6	Specialty medical care is related to HIV infection or conditions arising from the use of HIV medications (i.e., side effects).	• Condition is confirmed by review of applicable documentation in service records.
1.7	All tests are: • Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider; • Consistent with medical and laboratory standards; and • Approved by the Food and Drug Administration (FDA) and certified under the Clinical Laboratory Improvement Amendments (CLIA) program.	• Condition is confirmed by review of applicable documentation in service records.

[5] See https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

1.8	A treatment plan exists that is appropriate to each client's age, gender, and specific needs, and that both provider and client have reviewed. Plans include, at a minimum: • Diagnostic information; • Referrals (as appropriate); • Discussion of risk reduction, HIV education, secondary prevention, and behavior modification (as appropriate); • Prophylaxis against opportunistic infections; • Preventive care (e.g., mammograms, pap smears, prostate screenings) that is age, gender, and health-status appropriate; • Medications (including a current list of prescribed medication or notations explaining the absence of prescriptions); and • Education related to treatment adherence and the management of side effects (as appropriate).	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by review of patient satisfaction survey results regarding level of involvement and understanding of treatment plan.
1.9	There is evidence of implementation of the treatment plan.	• Condition is confirmed by review of applicable documentation in service records.
1.10	Psychosocial, mental health and substance abuse screenings are conducted in the context of *Outpatient and Ambulatory Medical Care* within 30 days of the initial client visit and are reassessed annually.	• Condition is confirmed by review of applicable documentation in service records.
1.11	When psychosocial, mental health, or substance abuse needs are identified, clients are referred to a case manager or appropriate service provider.	• Condition is confirmed by review of applicable documentation in service records.
1.12	Staff follow-up with clients who miss medical visits to address barriers and to reschedule the appointment.	• Condition is confirmed by review of applicable documentation in service records.
1.13	Service is not provided in an emergency room, hospital, or any other type of inpatient treatment center.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

2. AIDS Drug Assistance Program (ADAP)

ADAP in the context of Part A is funding allocated to a HRSA-compliant, State-supported AIDS Drug Assistance Plan that provides an approved formulary of medications to low-income HIV-infected individuals for the treatment of HIV disease or the prevention of opportunistic infections.

These standards for *ADAP* are designed to ensure that:

- Part A funds are available to supplement the State-supported AIDS Drug Assistance Plan in an effort to delay or end an enrollment waiting list imposed by the State on its HIV Medical Services Program (which includes ADAP).

	STANDARD	MEASURE
2.1	In the event that the Indiana State Department of Health (ISDH) HIV Medical Services Program creates a waiting list for enrollment, the RWSP planning council is notified so that resource reallocations may be considered.	• Condition is confirmed by review of documented communications with ISDH. • Condition is confirmed by review of RWSP Planning Council minutes.
2.2	Contributions received from the RWSP are allocated by ISDH only to expenses associated with RWSP clients.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities.
2.3	All purchased drugs will adhere to the approved formulary of medications.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities. • Condition is confirmed by quarterly review of current formulary.
2.4	The formulary includes pharmaceutical agents from all the classes approved in the *Clinical Practice Guidelines for use of Antiretroviral Agents in HIV-1 infected Adults and Adolescents*[6] and meets the minimum requirements from all approved classes of medications according to these guidelines.	• Condition is confirmed by quarterly review of current formulary.
2.5	ISDH policies and procedures exist for access, monitoring, and compliance with the funding ratio requirement.	• Condition is confirmed by review of ISDH policies.
2.6	An ISDH eligibility process exists which requires documentation in client records of low-income status and eligibility based on a specified percent of the Federal Poverty Level (FPL) and proof of an individual's HIV-positive status and Indiana residency.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes proof of client eligibility including HIV status, TGA residency, and low-income status as defined by the State based on a specified percent of the FPL.

[6] https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf

2.7	A specific process is used by ISDH to secure the best price available (e.g., the prices established by the 340B Drug Pricing Program under Public Law 102-585) for all products.	• Condition is confirmed by review of ISDH policies and reports of the number of individuals served, the medications provided, and costs per medication.

3. Local AIDS Pharmaceutical Assistance Program (LPAP)

LPAP includes local drug assistance programs to provide emergency HIV medications to clients. LPAPs are not AIDS Drug Assistance Programs (ADAPs) and are not intended to provide long term assistance. However, they are consistent with the most current *Clinical Practice Guidelines for use of Antiretroviral Agents in HIV-1 infected Adults and Adolescents* and are coordinated with the State's Part B ADAP. Though emergency in nature, LPAPs observe all standard enrollment and eligibility processes and ensure uniform benefits for all eligible clients throughout the TGA. Programs utilize a drug formulary approved by the TGA's planning council and maintain systems to dispense and track medications and manage drug therapy. LPAP funds are not used for *Emergency Financial Assistance (EFA)* purposes.

These standards for *LPAP* are designed to ensure that participating pharmacies:

- Provide limited, emergency access to drug treatments to eligible persons with HIV disease (as prescribed by a client's physician) in a timely and reliable manner that allows the client to adhere to prescribed treatment regimens.

	STANDARD	MEASURE
3.1	Participating pharmacies establish a formal relationship with MCPHD (either through a memorandum of understanding or a business associate agreement) which attests to: • The pharmacy's ability to confirm client enrollment and eligibility; • The availability of uniform benefits for all enrolled clients throughout the TGA, and • The existence of adequate systems to manage drug therapy, track the distribution of medications, and ensure that dispensed medications are consistent with the current treatment guidelines and the formulary approved by the TGA's planning council.	• Memoranda of understanding and business associate agreements are current, on file, and available for review. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.2	Participating pharmacies are able to provide medications at or below the prices established by the 340B Drug Pricing Program.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.3	Providers adhere to all applicable state and federal laws, rules, and regulations governing the dispensing of medications.	• Applicable licenses are current, on file, and available for review. • Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.4	Providers maintain stock adequate to fill any valid prescription for an allowed drug (or any medically necessary substitutions as authorized by the RWSP on an individual basis) upon presentation by an eligible client.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.

3.5	Providers have the ability to immediately incorporate any service caps which may be imposed by the RWSP (including the potential limitation of covered medications to only those identified as essential HIV therapies).	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.6	Providers receive authorization from the RWSP prior to all (initial and any subsequent) dispensings.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that a dispensing is **not**: a component of a primary medical visit, a single occurrence of short duration (an emergency) without arrangements for longer term access to medication, or in the form of a voucher.
3.7	Providers limit initial assistance to one 30-day (or less) supply per valid prescription.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.8	The RWSP requires the referring case management agency to document the following in order to authorize initial assistance: • Client is duly enrolled in the program; • Medication assistance is noted in care plan; • Patient Assistance Program application has been initiated; • ISDH Medical Services Program application has been initiated; and • Indiana Medicaid application has been initiated.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.9	The RWSP requires the referring case management agency to document the following in order to authorize any additional assistance: • Client is duly enrolled in the program; • Medication assistance is noted in care plan; • Patient Assistance Program application has been completed and submitted; • ISDH Medical Services Program application has been completed and submitted; and • Indiana Medicaid application has been completed and submitted.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

3.10	Within an assistance period, providers may supply an alternative to a previously dispensed medication if presented with a new prescription (implying that the therapy has been changed by the prescribing physician for medical reasons).	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
3.11	Providers accept reimbursement from the RWSP as "payment in full" and do not request or accept any payments directly from eligible clients.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
3.12	Providers do not attempt to bill the RWSP for any portion of any cost for which there is a known full or partial payer other than the RWSP.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

4. Oral Health Services

Oral Health Services includes outpatient diagnostic, preventive, and therapeutic oral health services in compliance with state dental practice laws, informed by the American Dental Association Dental Practice Parameters, based on an oral health treatment plan, adherent to specified service caps, and provided by licensed and certified dental professionals, including general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained providers.

These standards for *Oral Health Services* are designed to ensure that agencies:

- Provide access to high-quality routine and emergency dental care for persons living with HIV disease who reside within the Indianapolis TGA who have no dental third party payment source, who have limited third party coverage, or who have been denied coverage by a third party payer.

	STANDARD	MEASURE
4.1	Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries possessing the appropriate and valid licensure and certification, based on State and local laws.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
4.2	A health history assessment is obtained annually and includes: • Contact information for primary care provider (PCP); • Consult on file from PCP; • Current medications and changes in regimen; • Allergies (baseline); • Laboratory data; • Hepatitis B and C status (baseline); and • CD4 count and viral load results.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes assessment notes signed by the provider.
4.3	An intraoral exam is performed every six months (or more frequently if indicated in client's treatment plan) and includes: • Dental caries examination; and • Soft tissues examination.	• Condition is confirmed by review of applicable documentation in service records. – Documentation of pathology of cheeks, tongue, palate, gingival, mucosa, pharynx, frenum, or floor of mouth is sufficient to indicate that a soft tissues examination was performed.

4.4	A periodontal exam is performed every six months or more frequently if indicated in client's treatment plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation of examination of pocket depths, gingival inflammation, plaque index, fremitus, recession, bleeding assessment, or tooth mobility is sufficient to indicate that a periodontal exam was performed.
4.5	An extraoral (head and neck) exam is performed every six months or more frequently if indicated in client's treatment plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation of examination of facial symmetry, lymph nodes, thyroid glands, or lips is sufficient to indicate that an extraoral exam was performed.
4.6	A written treatment plan exists that is updated every six months and is consistent with American Dental Association guidelines. The client chart contains: • A summary of existing conditions; • Problems; • Course of action; • Maintenance program; and • Documentation that treatment options were discussed with client.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a treatment plan and related notes signed by the oral health professional rendering the services.
4.7	Oral health education should be provided to the patient every six months that includes: • Caries prevention (e.g., oral hygiene instruction, dietary counseling); • Smoking cessation; and • Discussion of patient's health status (including current CD4 count and viral load test results).	• Condition is confirmed by review of applicable documentation in service records.
4.8	Clinical decisions are supported by the American Dental Association Dental Practice Parameters.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes assessment notes in the service record signed by the provider.
4.9	The agency has systems in place to deliver client reminders and is able to document that a reminder was sent to the client.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.

4.10	Providers recognize that services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the number of procedures, or a combination of any of the above, as determined by the RWSP.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

5. Early Intervention Services (EIS)

EIS activities include targeted HIV testing (to help the unaware learn of their HIV status); monitored referrals to case management and treatment services at key points of entry for those found to be HIV-infected; linkage services designed to facilitate access to HIV care and treatment services such as *Outpatient and Ambulatory Medical Care*, *Case Management*, and *Substance Abuse Treatment Services*; and health education and literacy training that enable clients to navigate the HIV system of care and reduce future transmission of disease. RWSP funds may be used for HIV testing only as necessary to supplement-- not supplant -- existing funding.

Special Note: *EIS* is often confused with *Outreach Services*. To clarify, *EIS* activities are designed to identify HIV-positive persons who are *unaware* of their status and to facilitate their entry into care. The service has four distinct components: testing, referral, linkage, and health education. Conversely, *Outreach Services* are activities *other than counseling and testing* designed to identify known HIV-positive persons and link them to medical and support services. These persons are commonly referred to as "out-of-care" or "lost-to-care." This service shares with *EIS* only the referral and linkage components and has an entirely different target population.

These standards for *EIS* are designed to ensure that agencies:

1. Adhere to practices endorsed by the Centers for Disease Control and Prevention (CDC);
2. Target high risk areas and populations for intervention; and
3. Link testing to prompt entry into care.

	STANDARD	MEASURE
5.1	Providers complete the standard *Fundamentals of HIV Prevention Counseling Course* offered by ISDH prior to the provision of services and maintain certification as required by ISDH.	• Documentation is present in personnel files and available for review.
5.2	Providers adhere to the CDC-compliant specimen submission policies established by the HIV Prevention Program at ISDH and any applicable local protocols, including CareWare data entry requirements.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes the number of HIV tests and positive results, as well as where and when RWSP-funded HIV testing occurred.

5.3	Providers target *Early Intervention Services* to only those populations and locations which are epidemiologically evidenced to be at high risk for HIV infection.	• Condition is confirmed by review of epidemiologic data presented in the grant application. • Condition is confirmed by review of documentation of in-coming referrals for testing from key points of entry. • Condition is confirmed by review of documentation of any grantee approval to provide EIS services in points of entry not included in original scope of work.
5.4	Providers adhere to grantee-approved protocols for linking clients into care consistent with the *Procedure for the Notification of All Newly Diagnosed HIV* policy established by ISDH which requires providers to: • Contact the chosen HIV Care Coordination site (key point of entry into care) while with the client to schedule an appointment or, if after hours, to follow-up with the care site within two days after Release of Information has been sent; • Send a Release of Information signed by the client to the chosen care site; and • Follow-up with the care site within 10 working days of the original encounter to determine the success of the referral.	• Written policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review. • Condition is confirmed by review of written memoranda of understanding with key points of entry into care to facilitate access to care for those who test positive. • Condition is confirmed by review of applicable documentation in service records.
5.5	Providers provide culturally competent health education and literacy training to help enable clients to navigate the HIV system.	• Condition is confirmed by review of applicable documentation in service records.
5.6	Providers follow-up directly with clients when a referral has been determined to be unsuccessful and at least three “good faith” attempts are made to contact the client.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
5.7	Providers coordinate with existing HIV prevention efforts and programs to avoid duplication and provide HIV testing only where existing federal, state, and local funds are not adequate (ensuring that RWSP funds supplement and do not supplant existing funds for testing).	• Written tracking and billing procedures are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review.

6. Health Insurance Premium and Cost-Sharing Assistance

Health Insurance Premium and Cost-Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain health insurance or to receive medical benefits under a health insurance program. This includes premium payments made through ISDH to the state's high-risk insurance pool, the federal Health Insurance Marketplace, or any similar insurance mechanisms.

Additional allowable services include payments for stand-alone dental insurance premiums to provide comprehensive oral health care services for eligible clients and cost-sharing assistance on behalf of medically insured clients.

These standards for *Health Insurance Premium and Cost-Sharing Assistance* are designed to ensure that:

1. Clients in outlying counties have equal access to care compared to the residents of Marion County; and
2. *Health Insurance Premium and Cost-Sharing Assistance* funds are used to maximize the number of HIV-positive TGA residents who have access to primary HIV-related medical care.

	STANDARD	MEASURE
6.1	ISDH purchases only major medical policies which provide to clients comprehensive primary care and a drug formulary with a full range of HIV medications which includes, at a minimum, at least one drug in each class of core antiretroviral therapeutics as defined by the Department of Health and Human Services (DHHS).	• Condition is confirmed by review of the actual policies purchased.
6.2	Premiums are paid first for RWSP clients residing in counties other than Marion.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities.
6.3	In the event that the ISDH HIV Medical Services Program creates a waiting list for enrollment, the RWSP planning council is notified so that resource reallocations may be considered.	• Condition is confirmed by review of documented communications with ISDH. • Condition is confirmed by review of RWSP Planning Council minutes.

7. **Home Health Care**

Home Health Care is the provision of services provided in the patient's home by licensed health care workers such as nurses and includes the administration of intravenous and aerosolized treatment, parenteral feeding, preventive and specialty care, wound care, routine diagnostic testing, and other medical therapies. It specifically excludes personal care.

The provision of *Home Health Care* is limited to clients who are homebound. Home settings do not include nursing facilities or inpatient mental health or substance abuse treatment facilities.

These standards for *Home Health Care* are designed to ensure that agencies:

- Comply with Indiana state regulations, including licensing requirements, for home health care workers.

	STANDARD	MEASURE
7.1	Services are provided by home health care workers with appropriate licensure as required by State and local laws.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
7.2	Services are limited to medical therapies in the home and exclude personal care services.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the number and type of services provided and is accompanied by the provider's signature.

8. **Home and Community-Based Health Services**

Home and Community-Based Health Services are skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. Allowable services include durable medical equipment; home health aide and personal care services; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostic testing; and appropriate mental health, developmental, and rehabilitation services. Non-allowable services include inpatient hospital services and services within nursing homes and other long term care facilities.

These standards for *Home and Community-Based Health Services* are designed to ensure that agencies:

1. Comply with state and local laws, including licensing and certification requirements, for home-based health services; and
2. Deliver services based on a documented multidisciplinary care plan.

	STANDARD	MEASURE
8.1	Individuals providing the services possess the appropriate licensure and certifications as required by local and state laws.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
8.2	All 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.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written care plans with appropriate content and signatures and which are consistently prepared and updated as needed.
8.3	Care plans specify the types of services needed and the quantity and duration of services.	• Condition is confirmed by review of applicable documentation in service records.
8.4	All planned services are allowable within the service category.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
8.5	Service provision records: • Document the types, dates, and location of services; • Include the signature of the professional who provided the service at each visit; and • Indicate that services are provided in accordance with allowable modalities and locations under the definition of home and community based health services.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the types of home services provided, dates provided, the location of the service, and the signature of the professional who provided the service at each visit.

9. **Hospice Care**

Hospice Care is medical care provided by licensed hospice care providers to clients in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Allowable services include room, board, nursing care, mental health counseling, physician services, and palliative therapeutics. This service category does not extend to skilled nursing facilities or nursing homes.

These standards for *Hospice Care* are designed to ensure that agencies:

1. Comply with state and local laws, including licensing requirements, for hospice care; and
2. Deliver services only in the appropriate settings.

	STANDARD	MEASURE
9.1	Providers possess appropriate and valid licensure as required by the State of Indiana.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
9.2	A physician certifies that the patient's illness is terminal as defined under Medicaid hospice regulations (i.e., having a life expectancy of six months or less).	• Condition is confirmed by review of applicable documentation in service records.
9.3	Providers document the following: • The types of services provided (indicating that only allowable services have been delivered); and • The locations where hospice services are provided (indicating that services have been provided only in a home, other residential setting , or a non-acute care section of a hospital designated and staffed as a hospice setting).	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes an indication that the services are RWSP-allowable, are in accordance with the provider contract and scope of work, and have been delivered in permitted setting.
9.4	Counseling services provided under *Hospice Care* : • Meet Medicaid and other applicable requirements; • Are consistent with the definition of mental health counseling; and • Are provided by mental health professionals (psychiatrists, psychologists, or licensed clinical social workers) who are licensed or authorized within Indiana.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that any counseling services meet Medicaid or other applicable requirements as specified in the contract.

9.5	Palliative therapies provided under *Hospice Care* : • Meet Medicaid and other applicable requirements; and • Are consistent with those covered under Indiana's Medicaid program.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that any palliative therapies meet Medicaid or other applicable requirements as specified in the contract.

10. Mental Health Services

Mental Health Services are outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to individuals with a diagnosed Axis 1 or 2 mental illness, based on a detailed treatment plan, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within Indiana to render such services (or a person under the supervision of such a professional). This typically includes psychiatrists, psychologists, and licensed clinical social workers.

These standards for *Mental Health Services* are designed to ensure that:

- Programs assess and respond appropriately to routine and emergency psychosocial, cognitive, and emotional needs of clients with a range of psychosocial issues.

	STANDARD	MEASURE
10.1	Staff possess appropriate and valid licensure and certification as mental health professionals as required by the State of Indiana.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
10.2	Each client receives a formal assessment using a recognized, evidence-based diagnostic tool upon entry into mental health care within the first two sessions, except when documented reasons exist that preclude this standard from being met. Every assessment will address at a minimum: • Suicide ideation; • Crisis needs; • Medication needs; • Substance use; • Psychotherapy needs; • Mental health treatment history; and • Sexual and drug use risk-taking behavior.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a written assessment completed during the first or second session and, if completed after the second session, an explanation for the delay.
10.3	Providers create or adapt an individualized, written treatment plan for each client. Every plan includes: • One or more problem statements and associated goals developed to address the identified need(s); • The diagnosed mental illness or condition; • The treatment modality; • Start date for mental health services; • Recommended number of sessions; • Date for reassessment; • Projected treatment end date; and • Any recommendations for follow-up.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a written plan signed by the client and the rendering mental health professional.

10.4	Notes in the service record reflect progress on and recommended updates to the treatment plan, as well as collaborations and information exchanges with other providers and members of the treatment team.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes notes which clearly document that the provided services are allowable under RWSP guidelines and are consistent with the treatment plan.
10.5	Reasons for case closure are documented when applicable. Notes reflect attempts to provide continuity of care (such as linkage with another service, attempts to contact client, or a plan for after-care) prior to closure. Allowable reasons for closure include: • The client has requested termination of services; • Goals of the treatment plan have been achieved (upon mutual agreement by provider and client); • The client has moved out of the service area or is otherwise no longer eligible; • The agency has had no contact with the client for 12 months or more; and • The client is deceased.	• Condition is confirmed by review of applicable documentation in service records.
10.6	Efforts are made to engage and maintain clients in primary care.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of contact with the established primary care provider or coordination with case management personnel.
10.7	The mental health provider coordinates medication management with primary care and other prescribing providers as appropriate.	• Condition is confirmed by review of applicable documentation in service records.
10.8	Providers respond to requests for non-emergency mental health services within 10 business days and have a protocol in place for responding to more time-sensitive emergencies.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
10.9	Providers deliver the appropriate level of service for the client based on the client's ability and willingness to participate, and providers immediately refer clients for whom the services offered are not suitable.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.

10.10	Providers engage in one-on-one risk assessments with clients to help assess personal risk factors for HIV transmission and refer as appropriate for risk-reduction counseling.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written progress notes.
10.11	Staff follow-up with clients who miss scheduled visits to address barriers and reschedule the appointment, communicating with other providers, (including case managers) as needed to maximize retention in care.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of attempts to contact client in signed, dated progress notes.

11. **Medical Nutrition Therapy**

Medical Nutrition Therapy is a service that includes nutrition assessment and screening, dietary and nutritional evaluation, food and nutritional supplements, and nutrition education and counseling. It is provided outside of a primary care visit by a licensed registered dietician. All services are provided pursuant to a physician's recommendation and are based on a nutritional plan developed by a licensed registered dietician.

These standards for *Medical Nutrition Therapy* are designed to ensure that agencies:

1. Comply with state and local laws, including licensing and registration requirements, for dieticians; and
2. Deliver services only after the development of a comprehensive nutritional plan.

	STANDARD	MEASURE
11.1	The provider is a licensed and registered dietician as required by the State of Indiana.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
11.2	Where food is provided to a client under this service category, a client record is maintained that includes a physician's recommendation and a dietician's nutritional plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a physician's recommendation and a nutritional plan developed by a licensed registered dietician.
11.3	The nutritional plan includes: • Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food; • Date that service is to be initiated; • Planned number and frequency of sessions; and • The signature of the registered dietician who developed the plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a nutritional plan which includes the recommended services, proposed quantities, initiation date, frequency of service, and the provider's signature.
11.4	The service record includes: • The name, type, and quantity of all nutritional supplements and food provided; • The signature of each registered dietician who rendered service; • The date of service; • The date of reassessment (when applicable); • The date of termination of medical nutrition therapy (when applicable); and • Any recommendations for follow-up.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the services provided, the quantity of nutritional supplements and food provided, the dates of services, the physician's recommendation for the provision of food, and the rendering provider's signature.

12. **Medical Case Management Services (including treatment adherence)**

Medical Case Management includes a range of client-centered services that focus on improving health outcomes in support of the HIV care continuum. The coordination and follow-up of medical treatments is the primary component of medical case management. This service provides timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care personnel who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.

Key activities include initial assessment of service needs; development of a comprehensive, individualized service plan; coordination of services required to implement the plan; continuous client monitoring to assess the efficacy of the plan; periodic re-evaluation and adaptation of the plan as necessary but at least every six months; on-going assessment of the client's and other key family members' needs and personal support systems; and client-specific advocacy and review of utilization of services. *Medical Case Management* also includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV disease treatments.

These standards for *Medical Case Management* are designed to ensure that:

1. Clients have access to the highest quality of care through experienced and trained medical case managers;
2. Case managers are provided the training and supervision to enable them to perform their jobs well;
3. Clients are informed of available services and what they can expect if they are referred for medical management intervention;
4. Clients' decisions and needs drive the medical case management process;
5. Client level data is tracked for reporting and quality improvement purposes; and
6. Clients who receive medical case management services have access to primary medical care, medications, and assistance designed to identify and remove barriers to receiving medical care or adhering to a prescribed treatment plan.

	STANDARD	MEASURE
12.1	Service providers are trained professionals, either medically credentialed persons or other health care personnel who are part of the clinical care team.	• Documentation is present in personnel files and available for review.
12.2	Providers receive a minimum of 20 hours of job-related trainings per year; six of those hours must earn CEUs.	• Documentation is present in personnel files and available for review. – Documentation includes evidence that training topics cover (at minimum): mental health, chemical dependency, Medicaid, cultural competency, confidentiality, HIV treatment, and current epidemiological trends.

12.3	Staff provide a service distinct from ISDH HIV Care Coordination (and Part A non-medical case management), one that focuses on disease management for those experiencing treatment challenges.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
12.4	Referrals are accepted for patients who meet specific medical criteria.	• Condition is confirmed by review of applicable documentation in service records.
12.5	The intervention is session-limited, runs concurrent with (and does not replace) standard case management services, and includes a process to communicate successes and remaining challenges to the HIV Care Coordinator or Non-Medical Case Manager at the completion of the intervention.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

12.6	All clients are assessed for specific treatment challenges within 30 days of initial client visit (and, if applicable, reassessed annually) including:
	• Primary medical care needs;
	• Medication needs;
	• Access to medications;
	• Medication adherence;
	• Coordination of multiple physicians;
	• Oral health care needs;
	• Mental health needs;
	• Substance abuse needs; and
	• Need for HIV Care Coordination or Non-Medical Case Management to address concerns related to:
	  • Eligibility for benefits such as Medicaid, Medicare, Veteran's Administration;
	  • Eligibility for other public insurance options including the Healthy Indiana Plan (HIP) and the ISDH HIV Medical Services Program;
	  • Other psychosocial needs (including domestic violence screening);
	  • Legal needs;
	  • Supportive service needs (including but not limited to transportation, food, financial and housing needs); and
	  • Knowledge of HIV disease, disclosure requirements, and risk reduction techniques.
		• Condition is confirmed by review of applicable documentation in service records.
		  – Documentation includes evidence of mental health and substance abuse screenings having been performed by the medical case manager or evidence of communication with a provider who has contacted such screening.

12.7	The following activities are performed to address the client's treatment challenges: • Development of a comprehensive, individualized service plan; • Treatment adherence counseling; • Coordination of other services required to implement the individualized service plan; • Continuous client monitoring to assess the efficacy of the individualized service plan; • Continuous coordination with the primary HIV Care Coordinator or Non-Medical Case Manager; and • Periodic re-evaluation and adaptation of the plan (at least every six months).	• Condition is confirmed by review of applicable documentation in service records.
12.8	All individualized service plans address: • Client challenges and proposed interventions; • Client goals and expected outcomes; • Resources available and referrals made; • Person responsible for action steps in the individualized service plan; and • Time frame for completion of action steps in the individualized service plan.	• Condition is confirmed by review of applicable documentation in service records.
12.9	Providers provide a copy of the individualized service plan to the client when it is created and every time it is significantly altered.	• Condition is confirmed by review of applicable documentation in service records.
12.10	Providers document all encounters and services rendered, including: • Types of services provided; • Types of encounters and communications; and • Duration and frequency of the encounters.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
12.11	Each encounter relates to the treatment challenges described by the client and focuses on: • Treatment adherence counseling; • Coordination and follow-up of medical treatments; • Ongoing assessment of client's and other key family members' needs and personal support systems; • Client-specific advocacy; • Coordination with HIV Care Coordination or Non-Medical Case Management to ensure linkage to other client-centered services and to facilitate access to other public and private programs for which the client may be eligible.	• Condition is confirmed by review of applicable documentation in service records.

12.12	Staff follow-up with clients who miss scheduled medical visits to address barriers and to reschedule the appointment.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of attempts to contact client in signed, dated progress notes.

13. Substance Abuse Treatment Services – Outpatient

Substance Abuse Treatment Services include the provision of medical or other types of treatment rendered by a physician (or other professional under the supervision of a physician) to address chemical dependency as well as the provision of counseling to address substance abuse problems by a physician, therapist, or other qualified personnel. All services must be rendered in out-patient settings.

Services include screening, assessment, diagnosis, and treatment of substance use disorders. Allowable activities include pre-treatment ("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, and relapse prevention services.

These standards for outpatient *Substance Abuse Treatment Services* are designed to ensure that:

- Programs comply with Indiana state regulations, including licensing requirements, for substance abuse services.

	STANDARD	MEASURE
13.1	Provider qualifications are documented with degrees, certifications, and training records according to the scope of practice, agency policy, and Indiana law, and as dictated by Substance Abuse and Mental Health Services Administration (SAMHSA) standards.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
13.2	The agency has policies and procedures to assess, screen, and address, at minimum: • Mental health needs; • Functional needs; and • Medical needs.	• Written policies are current, on file, and available for review.
13.3	Providers deliver the appropriate level of service for the client based on the client's ability and willingness to participate, and providers immediately refer clients for whom the services offered are not suitable.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
13.4	In the event of any delay to accessing care (including delays due to the client's stage of recovery readiness), reasonable attempts will be made to maintain communication with the client for the purpose of preserving engagement with the substance abuse treatment system.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of consistent client contact. – Documentation includes evidence of referrals to or the provision of support services to maintain client engagement.

13.5	Each client receives a formal assessment using a recognized, evidence-based diagnostic tool upon entry into substance abuse treatment within the first two sessions, except when documented reasons exist that preclude this standard from being met.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a written assessment completed during the first or second session and, if completed after the second session, an explanation for the delay.
13.6	Providers create or adapt an individualized treatment plan for each client. Every plan calls for only allowable activities and includes: • The quantity, frequency, and modality of treatment provided; • The date treatment begins and ends; and • Regular monitoring and assessment of client progress.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a written plan signed by the client and the rendering substance abuse treatment professional.
13.7	Providers engage in one-on-one risk assessments with clients to help assess personal risk factors for HIV transmission and refer as appropriate for risk-reduction counseling.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written progress notes.
13.8	Counseling is regularly offered to clients on the conditions commonly contributing to the continued use or abuse of drugs and alcohol.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written progress notes.
13.9	Reasons for case closure are documented when applicable. Notes reflect attempts to provide continuity of care (such as linkage with another service, attempts to contact client, or a plan for after-care) prior to closure. Allowable reasons for closure include: • The client has requested termination of services; • Goals of the treatment plan have been achieved (upon mutual agreement by provider and client); • The client has moved out of the service area or is otherwise no longer eligible; • The agency has had no contact with the client for 12 months or more; and • The client is deceased.	• Condition is confirmed by review of applicable documentation in service records.

13.10	Staff will follow-up with clients who miss scheduled visits to address barriers and reschedule the appointment, communicating with other providers, (including case managers) as needed to maximize retention in care.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of attempts to contact client in signed, dated progress notes.

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14. Case Management (non-medical)

Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. Activities may include benefits and entitlements counseling and referral activities to assist eligible clients in obtaining access to public and private programs for which they may be eligible. *Case Management* includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the recipient.

Key activities include initial assessment of service needs; development of a comprehensive, individualized care plan; continuous client monitoring to assess the efficacy of the care plan; re-evaluation of the care plan at least every six months with adaptations as necessary; and on-going assessment of the client's and other key family members' needs and personal support systems. *Case Management* also includes transitional case management for incarcerated persons as they prepare to exit the correctional system.

These standards for *Case Management* are designed to ensure that:

1. Clients have access to the highest quality of care through experienced and trained case managers;
2. Case managers are provided the training and supervision to enable them to perform their jobs well;
3. Clients are informed of available services and what they can expect if they enroll in case management;
4. Clients' decisions and needs drive the case management process;
5. Client level data is tracked for reporting and quality improvement purposes; and
6. Clients who receive case management services have assistance in accessing primary medical care and medications and in identifying and removing barriers to receiving medical care or adhering to a prescribed treatment plan.

	STANDARD	MEASURE
14.1	Providers adhere to the guidelines established for HIV case management by the statewide HIV Care Coordination Program.	• Condition is confirmed by review of documentation of completion of ISDH certification training. • Condition is confirmed by review of applicable documentation in service records.

14.2	In accordance with the HIV Care Coordination guidelines, providers perform a multi-step process which ensures coordination and timely access to a range of appropriate medical and social services. This process includes, at a minimum, the following activities: • Client Identification and Recruitment; • Client Orientation, Initial Interview, and Assessment; • Development of the Individualized Care Plan; • Monitoring and Evaluation of the Individualized Care Plan; • Client Status Maintenance; • Crisis Intervention Activities; and • Termination and Discharge Planning.	• Condition is confirmed by review of applicable documentation in service records.
14.3	All assessments includes a review of the following: • Primary medical care needs; • Medication needs; • Access to medications; • Medication adherence; • Oral health care needs; • Mental health needs; • Substance abuse needs; • Eligibility for benefits such as Medicaid, Medicare, Veteran's Administration; • Eligibility for other public insurance options including HIP and the ISDH HIV Medical Services Program; • Other psychosocial needs (including domestic violence screening); • Legal needs; • Supportive service needs (including but not limited to transportation, food, finance and housing needs); and • Knowledge of HIV disease, disclosure requirements, and risk reduction techniques.	• Condition is confirmed by review of applicable documentation in service records.
14.4	Specifically, psychosocial, mental health, and substance abuse screenings are conducted within 30 days of initial client visit and reassessed every six months (at minimum).	• Condition is confirmed by review of applicable documentation in service records.

14.5	Services include, but are not limited to, the following: • Facilitating access to medical, social, community, legal, financial, and other services; • Facilitating access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services; • All types of encounters and communications (e.g., face-to-face, telephone contact,); and • Transitional case management for incarcerated persons provided either as part of discharge planning or for individuals who are in the correctional system for a brief period.	• Condition is confirmed by review of applicable documentation in service records.
14.6	Staff follow-up with clients who miss scheduled visits to address barriers and to reschedule the appointment.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of attempts to contact client in signed, dated progress notes.

15. Child Care Services

Child Care Services are reserved for the children of enrolled HIV-positive clients. They are provided intermittently, only for legal dependents that live in the household and only while the client attends medical or other appointments or RWSP-related meetings, groups, or training sessions.

Child Care Services may also be provided for enrolled HIV-positive children (regardless of the HIV or enrollment status of the parent). Services are provided intermittently and only while the enrolled child's parent (or legal guardian) attends RWSP-related meetings, groups, appointments, or training sessions.

Funds may be used to support a licensed or registered child care provider to deliver intermittent care, as well as informal child care 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).

Services may include recreational and social activities for the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities. Funds may not be used for off-premises social or recreational activities or gym memberships.

These standards for *Child Care Services* are designed to ensure that providers:

1. Comply with state and local laws, including licensing and registration requirements, for professional child care providers; and
2. Deliver services in a safe environment that limits liability for the client, provider, and the RWSP.

	STANDARD	MEASURE
15.1	Providers possess appropriate and valid licensure and – in cases where the services are provided in a day care or child care setting – are registered as child care providers under applicable State and local laws.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
15.2	The service provides care for children who are clients enrolled in the RWSP or the legal dependents of clients enrolled in the RWSP.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility and relationship of child to the parent or guardian.
15.3	The service is provided only to facilitate the client's receipt of other services covered by the RWSP (e.g., to attend medical appointments).	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the date and duration of each unit of child care service, as well as the reason that child care was needed.

15.4	Where child care is provided by a neighbor, family member, or other person, payments do not include cash payments to clients or primary caregivers for these services.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of compliance with grantee-required mechanism for handling payments for informal child care arrangements, documentation that no cash payments are being made to clients or primary care givers, and documentation that payment is for actual costs of service.
15.5	Liability release forms which are designed to protect the client, provider, and the RWSP are signed by the client (or parent or guardian, as applicable) prior to the provision of service.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes appropriate liability release forms that protect the client, provider, and the RWSP.
15.6	Recreational and social activities are provided only in a licensed or certified provider setting (including drop-in centers in primary care or satellite facilities).	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by a review of submitted claims or other contract monitoring activities. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that any recreational or social activities were provided within a certified or licensed provider setting.

16. Emergency Financial Assistance (EFA)

EFA is the limited provision of one-time or short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, access to nutrition (including groceries and food vouchers), and access to medications when other resources are not available. Though allowable by HRSA, the RWSP does not offer housing or transportation assistance under this category.

These standards for *EFA* are designed to ensure that:

1. Services are provided to clients who are eligible and in greatest need; and
2. Programs have exhausted all other options for meeting clients' needs.

	STANDARD	MEASURE
16.1	Eligibility for utility, food, and medication assistance is restricted by income and exhaustion of other available resources.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes proof of current monthly income and evidence of attempts made to access other resources.
16.2	Providers adhere to grantee-approved application criteria and protocols for the distribution of funds, including the following provisions: • Provider will not distribute payments directly to clients; • Provider will place no restrictions on requests for assistance with utility re-connection fees and past due balances; and • Provider will make payment for utility services only when in the name of the enrolled client.	• Written application criteria and policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review.
16.3	The RWSP requires the provider to document the following in order to authorize initial utility assistance: • Client is duly enrolled in the program; • Financial assistance is noted in care plan; • Assistance application has been initiated with the local Township Trustee; and • Request for assistance has been initiated with the particular local utility company.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

16.4	The RWSP requires the provider to document the following in order to authorize any additional utility assistance: • Client is duly enrolled in the program; • Financial assistance is noted in care plan; • Recent assistance application with the local Township Trustee has been denied; and • Recent request for assistance with the particular local utility company has been denied.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
16.5	The RWSP requires the provider to document the following in order to authorize initial emergency food assistance: • Client is duly enrolled in the program; • Food assistance is noted in care plan; • Application for food stamps has been initiated; • The need cannot currently be addressed under the *Food Bank and Home-Delivered Meals* category; and • All other local food pantry options have been exhausted.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
16.6	The RWSP requires the provider to document the following in order to authorize any additional emergency food assistance: • Client is duly enrolled in the program; • Food assistance is noted in care plan; • Application for food stamps has been denied; • The need cannot currently be addressed under the *Food Bank and Home-Delivered Meals* category; and • All local food pantry options remain exhausted.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
16.7	Providers assist clients with emergency access to medication through the use of RWSP-approved mechanisms, provide assistance only when similar services are not immediately available under the *LPAP* category, and adhere to all applicable standards described in Section 3.	• Written policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review.

16.8	Providers document that: • Assistance to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee; • Assistance is provided only for allowable utility, food, and medication expenses; • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients; • Emergency funds are allocated, tracked, and reported by type of assistance; and • The RWSP is the payer of last resort	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility, the need for assistance, and the types of assistance provided with dates and methods. – Documentation includes evidence that all assistance was for allowable items, was used only in cases where the RWSP was the payer of last resort, met grantee-specified limitations on amount and frequency of assistance to an individual client, and was provided through allowable payment methods. • Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include documentation of the number of clients served and the amount expended for each type of assistance category.

17. Food Bank and Home-Delivered Meals

Food Bank and Home-Delivered Meals services include the provision of actual food items, hot meals, or vouchers to purchase food. They may also include the provision of non-food items that are limited to personal hygiene products, household cleaning supplies, and water filtration or purification systems in communities where issues with water purity exist. No funds may be used for permanent water filtration systems for water entering the house, household appliances, pet foods, or other non-essential products. Appropriate licensure or certification for food banks and home delivered meals must be documented where required under State or local regulations. This service is distinct from *Medical Nutrition Therapy*, a core service, which requires a nutritional plan developed by a licensed registered dietician.

These standards for *Food Bank and Home-Delivered Meals* are designed to ensure that:

1. Services are provided to clients who are eligible and in greatest need; and
2. Programs have exhausted all other options for meeting clients' needs.

	STANDARD	MEASURE
17.1	Providers comply with federal, state, and local regulations including any required licensure or certification for the operation of food banks or the provision of home-delivered meals.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
17.2	Eligibility for food assistance is restricted by income and exhaustion of other available resources.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes proof of current monthly income and evidence of attempts made to access other resources.
17.3	Providers adhere to grantee-approved application criteria and protocols for the distribution of funds, including the provision that providers will not distribute payments directly to clients.	• Written application criteria and policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review.
17.4	Services are limited to food bank projects, home-delivered meals, and food voucher programs	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the type of service provided. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

17.5	Food bank projects that provide non-food items limit such items to personal hygiene products, household cleaning supplies, and water filtration or purification systems in communities where issues with water purity exist.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a description of actual items provided. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
17.6	Providers document and monitor the actual services provided, client eligibility, number of clients served, and level of services to these clients.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include documentation of the services provided by type of service, number of clients served, levels of service, and amount and use of funds for purchase of both food and approved non-food items.
17.7	The RWSP requires the provider to document the following in order to authorize initial food assistance: • Client is duly enrolled in the program; • Food assistance is noted in care plan; • Application for food stamps has been initiated; and • All other local food pantry options have been exhausted.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
17.8	The RWSP requires the provider to document the following in order to authorize any additional food assistance: • Client is duly enrolled in the program; • Food assistance is noted in care plan; • Application for food stamps has been denied; and • All local food pantry options remain exhausted.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

17.9	Providers document that: • Assistance to individual clients is provided with limited frequency and for limited periods of time, with frequency and duration of assistance specified by the grantee; • Payments are made either through a voucher program or short-term payments to the service entity, with no direct payments to clients; • Funds are allocated, tracked, and reported by type of assistance; and • The RWSP is the payer of last resort.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility, the need for assistance, and the types of assistance provided with dates and methods. – Documentation includes evidence that all assistance was for allowable items, was used only in cases where the RWSP was the payer of last resort, met grantee-specified limitations on amount and frequency of assistance to an individual client, and was provided through allowable payment methods. • Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include documentation of the number of clients served and the amount expended for each type of assistance category.

18. Health Education and Risk Reduction

Health Education and Risk Reduction services are those designed to educate PLWH about HIV transmission and how to reduce the risk of such transmission. It also includes the provision of information about available medical and psychosocial support services and counseling on how to improve their health status and minimize the risk of HIV transmission to others.

Topics may include risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention, health care coverage options (e.g., applicable benefits available through Medicaid, Medicare, and qualified health plans through the Health Insurance Marketplace), general health literacy, and the importance of treatment adherence.

Health Education and Risk Reduction services are specifically designed for PLWH that are aware of their status but not in care; however high risk HIV negative individuals or individuals unaware of their status will not be excluded from any of the HE/RR presentations should they desire to participate.

These standards for *Health Education and Risk Reduction* are designed to ensure that:

1. Providers are adequately qualified to deliver *Health Education and Risk Reduction* services; and
2. Services are delivered only to duly enrolled individuals.

	STANDARD	MEASURE
18.1	Providers have completed a standardized "Red Cross-equivalent" *HIV 101* training course.	• Documentation is present in personnel files and available for review.
18.2	Providers are able to explain to clients the benefits of: • Safe sex practices and other methods to reduce the risk of transmission; • Medical care for persons living with HIV; • Psychosocial support services; • The system of care for HIV-positive individuals in the Indianapolis TGA; and • The available resources in the Indianapolis TGA, including RWSP services.	• Documentation of applicable training is present in personnel files and available for review.
18.3	Providers educate enrolled RWSP clients about HIV transmission, how to reduce the risk of HIV transmission to others, and how to improve their health status.	• Condition is confirmed by review of the provider curriculum. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility and a description of the type of education provided.

18.4	Providers distribute and explain to enrolled RWSP client's information about available medical and psychosocial support services.	• Condition is confirmed by review of the literature provided. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility and a description of the type of materials provided.

19. Housing Services

Housing Services are the provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care.

Housing services include the development of an individualized housing plan, updated at least annually, to guide the client's linkage to permanent housing. They may also include these housing referral services: assessment, search, placement, and advocacy services.

These standards for *Housing Services* are designed to ensure that:

1. Services are provided to clients who are eligible and in greatest need;
2. Programs have exhausted all other options for meeting clients' needs; and
3. Programs evaluate the outcome of housing services based upon demonstrated measurable objectives.

	STANDARD	MEASURE
19.1	Services are provided by trained case managers or other professionals who possess a comprehensive knowledge of local, state, and federal housing programs and the how these programs can be accessed by clients.	• Written policies are current, on file, and available for review. • Documentation of applicable training is present in personnel files and available for review.
19.2	Eligibility for housing assistance is restricted by income and exhaustion of other available resources.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes proof of current monthly income and evidence of attempts made to access other resources.
19.3	Eligibility is further restricted by the demonstrated need for housing in order to gain or maintain access to HIV-related medical care, stay adherent to treatment regimes, prevent loss of housing, or alleviate homelessness.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of inability to adhere to medication, maintain consistent medical care due to housing instability, afford current housing costs, or secure safe and affordable housing.
19.4	The agency works with clients who have need for stable long term housing to establish a plan for achieving this goal and provide assistance in identification, re-location, and ensuring the individual or family is moved to or capable of maintaining a stable long-term living situation.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a written housing plan.

19.5	Providers adhere to grantee-approved application criteria and protocols for the distribution of funds, including the following provisions: • Provider will not distribute payments directly to clients; • Provider will make payment for housing assistance only when in the name of the enrolled client; • Assistance will not be provided for housing on a long term basis (i.e., multiple, consecutive months); and, • Funds may not be used for mortgage payments.	• Written application criteria and policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review. • Condition is confirmed by review of the process used to place clients on the wait list during the last year.
19.6	Providers adhere to grantee-approved selection criteria and protocols designed to allow newly identified client's access to needed housing services.	• Written application criteria and policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review. • Condition is confirmed by review of the process used to approve applicants for assistance during the last year.
19.7	Providers limit assistance only to the following categories: • Limited, month-to-month assistance with rent in order to prevent loss of housing; or • Immediate, short-term housing (e.g., hotel accommodations) in order to alleviate homelessness (not to exceed one month).	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
19.8	The RWSP requires the provider to document the following in order to authorize initial housing assistance: • Client is duly enrolled in the program; • Housing assistance is noted in care plan; • Housing Opportunities for Persons With AIDS (HOPWA) application has been initiated; • Section 8 application has been initiated; and • Shelter Plus Care application has been initiated for eligible individuals.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of ineligibility for Shelter Plus care (if applicable). • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

19.9	The RWSP requires the provider to document the following in order to authorize any additional housing assistance: • Client is duly enrolled in the program; • Housing assistance is noted in care plan; • Recent HOPWA application has been denied; • Recent Section 8 application has been denied; and • Recent Shelter Plus Care application has been denied (as applicable)	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
19.10	Providers document that funds are used only for allowable purposes, including: • The provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care; and • Housing-related referral services including housing assessment, search, placement, advocacy, and associated fees.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include documentation of the number of clients served, duration of housing services, types of housing provided, types of housing referral services, and evidence that no RWSP funds were used to provide direct payments to clients. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility, services provided (including referral services), and assistance provided to help obtain stable long-term housing.
19.11	The following is documented for each emergency housing assistance applicant: • Nature of the emergency; • Amount of assistance provided; • Third party to whom payment was sent; and • Reasons for denial of services and referrals provided, if applicable.	• Condition is confirmed by review of applicable documentation in service records.
19.12	Providers notify the client of payment distribution or request denial within two working days of the distribution or denial decision.	• Condition is confirmed by review of applicable documentation in service records.

20. Legal Services (including permanency planning)

Legal Services include the provision of advice and representation to (or on behalf of) an enrolled HIV-positive client regarding matters specifically related to the person's HIV status.

These standards for *Legal Services* are designed to:

1. Reduce barriers to accessing health-related legal documents; and
2. Ensure that a person's HIV status does not prevent access to care, benefits, employment, or housing accommodations.

	STANDARD	MEASURE
20.1	Providers employ licensed attorneys who have specific experience and appropriate training in advising on health-related matters and discrimination.	• Documentation is present in personnel files and available for review.
20.2	Providers deliver advice, assistance, and representation limited to these areas: • Assistance with public benefits such as Social Security Disability Insurance (SSDI); • Discrimination based on HIV status; • Breach of confidentiality related to HIV status; • Advance Directives (including living wills, durable powers of attorney, healthcare power of attorney, and "do not resuscitate" orders); • Health Care Representation; • Permanency planning to help clients make decisions about the placement and care of minor children after their parents or caregivers are deceased or are no longer able to care for them (including legal counsel regarding the drafting of wills, delegating powers of attorney, and preparing for custody options such as standby guardianship, joint custody, or adoption); and • 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.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes description of how the legal service is necessitated by the individual's HIV status, as well as the type of service and number of service hours provided.
20.3	Providers do not deliver services related to criminal defense or class action suits unless related to access to RWSP.	• Condition is confirmed by review of applicable documentation in service records.
20.4	The referring case management agency directs referrals directly to the RWSP who assigns the legal service provider.	• Condition is confirmed by review of applicable documentation in service records.
20.5	The referring case management agency maintains documentation of the client's need for legal services.	• Condition is confirmed by review of applicable documentation in service records.

20.6	Providers limit initial services to four hours.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
20.7	Providers request approval to deliver additional service hours (beyond the initial four hours) directly from the RWSP.	• Condition is confirmed by review of applicable documentation in service records.

21. Linguistic Services

Linguistic Services include the provision of oral interpretation and written translation services. They are provided by qualified linguistic service providers as a component of HIV service delivery when such services are necessary to facilitate communication between the provider and client and to support the delivery of RWSP-eligible services.

These standards for *Linguistic Services* are designed to ensure that:

1. Language is not barrier to any client seeking HIV related medical care and support; and
2. Linguistic services are provided in a culturally appropriate manner.

	STANDARD	MEASURE
21.1	Providers are appropriately trained, comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and, if applicable, hold relevant State or local certifications.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review. • Documentation of all relevant training is present in personnel files and available for review.
21.2	Providers offer services to the client only in connection with other RWSP-approved services (such as clinic visits).	• Condition is confirmed by review of applicable documentation in service records.
21.3	Providers deliver services to the client only to the extent that similar services are not available from another source (such as a translator employed by the clinic).	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
21.4	Providers respond to requests for services in a timely manner and work with direct HIV care providers to arrange appointments in a manner that minimizes the scheduling burden for the client.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
21.5	Providers deliver linguistic services in a manner that is sensitive to the culture of the client.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
21.6	Providers have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the client seeking assistance.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
21.7	To minimize losses due to clients who do not appear for scheduled appointments, providers contact the client directly at least once following the scheduling of the service but prior to the service date to confirm the appointment.	• Condition is confirmed by review of applicable documentation in service records.

21.8	Providers track all services delivered to ensure quality and appropriateness.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include documentation of the number and types of providers requesting and receiving services, number of assignments, languages involved, and types of services provided (oral interpretation or written translation).

22. Medical Transportation Services

Medical Transportation Services include non-emergency conveyance services provided, directly or indirectly, to clients to ensure access to HIV-related health and support services. Services may be provided through direct contracts with providers of transportation services, mileage reimbursement, or the establishment of voucher or pass systems. This category is not intended to support transportation costs incurred by providers in the course of providing care (e.g., traveling to see a patient).

These standards for *Medical Transportation Services* are designed to ensure that:

1. Transportation approved for reimbursement is accessible to eligible individuals living with HIV and their care givers; and
2. Transportation services are safe, timely, and reliable, and facilitate access to medical and support services.

	STANDARD	MEASURE
22.1	Drivers possess a valid Public Passenger Chauffeurs (PPC) driver's license, liability insurance (in accordance with Indiana law), and safe driving records (as defined by Health and Hospital Corporation policy).	• Documentation is present in personnel files and available for review.
22.2	Providers have the capacity to provide transportation that is accessible to individuals with disabilities.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of client feedback and agency response. • Documentation of ability to operate handicap equipment and to assist disabled riders as needed is present in personnel files and available for review.
22.3	Vehicles that are used to provide medical transportation contain first aid kits.	• Condition is confirmed during a site visit or other physical observation.
22.4	Vehicles that are used to provide medical transportation are registered and insured.	• Registrations and insurance documents are current, on file, and available for review.
22.5	Drivers abide by all Indiana laws including those related to adult and child safety restraints.	• Condition is confirmed during a site visit or other physical observation.
22.6	Drivers are certified in cardiopulmonary resuscitation (CPR) and American Red Cross First Aid protocols.	• Documentation is present in personnel files and available for review. – Documentation includes copies of certifications.
22.7	Providers have the capacity to transport persons accompanying the eligible client (limited to one documented caregiver or minor dependents of the client).	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.

22.8	Providers ensure that no more than one eligible client is transported at a time in a single vehicle (unless the consent and confidentiality agreements are obtained from all parties prior to service provision).	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records.
22.9	Services are provided only for transportation to RWSP-approved services.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. – Documentation includes the number of trips provided, the reason for each trip and its relation to accessing health and support services, trip origin and destination, client eligibility, the cost per trip, and the method used to meet the transportation need. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
22.12	With direct RWSP authorization, providers arrange for pick-up and delivery of medications to home-bound persons in limited emergency situations.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the RWSP authorization.
22.10	When utilized, providers track transportation vouchers to ensure proper use.	• Condition is confirmed by review of applicable documentation in service records. – Documentation describes the type of medical or support service appointment.

22.11	When utilized, providers ensure that mileage reimbursement does not exceed the federal per-mile reimbursement rate and that cash payments are not made directly to clients.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities. – Invoice details include evidence that the provider is meeting stated contract requirements with regard to methods of providing transportation (i.e., reimbursement methods do not involve cash payments to service recipients and mileage reimbursement does not exceed the federal reimbursement rate).
22.13	Vehicles that are used to provide medical transportation are routinely serviced and maintained every 3,000 miles.	• Vehicle maintenance documents are on file and available for review.
22.14	Providers ensure that these unallowable costs are not claimed for reimbursement from the RWSP: • Direct maintenance expenses (e.g., tires, oil changes, repairs, etc.) of a privately-owned vehicle; and • Any other costs associated with a privately-owned vehicle such as lease or loan payments, insurance, licensing, or registration.	• Condition is confirmed by a review of submitted claims or other contract monitoring activities.
22.15	Providers refer all clients who cannot be accommodated to alternate resources and notify the case manager on record.	• Condition is confirmed by review of applicable documentation in service records.
22.16	Providers document clients who fail to present for pick-up (i.e., “no shows”) and notify the case manager on record.	• Condition is confirmed by review of applicable documentation in service records.
22.17	Providers triage requests to prioritize transportation to medical care appointments.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.

22.18	Providers adhere to grantee-approved protocols for transporting clients which address: • Standardized guidelines for the delivery of transportation services; • Service limitations; • Use of safety belts; • Actions to be taken in the event of an accident; and • Prohibition of the use of cellular phones by drivers while in transit.	• Written policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review.

23. Outreach Services

Outreach Services are programs designed to engage (or re-engage) those known to be HIV-positive but not accessing the full array of available services for which they may be eligible, including *Outpatient and Ambulatory Medical Care.* Services may also include the provision of additional information and education on health care coverage options. Though services that result in contact with individuals who do not know their status are allowed (e.g., informing an individual who never received their test result), actual HIV counseling and testing is not allowed. Furthermore, this service cannot be delivered anonymously.

Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior; conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and designed to incorporate quantitative program reporting to enhance the effectiveness of program evaluation.

Special Note 1: *Outreach Services* are often confused with *EIS*. To clarify, *Outreach Services* are activities *other than counseling and testing* designed to identify known HIV-positive persons and link them to medical and support services. These persons are commonly referred to as "out-of-care" or "lost-to-care." Conversely, *EIS* activities are designed to identify HIV-positive persons who are *unaware* of their status and to facilitate their entry into care. *EIS* has four distinct components: testing, referral, linkage, and health education. It shares with *Outreach Services* only the referral and linkage components and has an entirely different target population.

Special Note 2: *Outreach Services* are also often confused with elements of *Case Management*. To clarify, *Outreach Services* are not intended to re-establish contact with existing clients who have missed recent appointments or failed to re-certify for services. They are intended to target individuals who have never been in care ("out-of-care") or who were once in care but have failed to engage in care in the most recent six-month period ("lost-to-care").

These standards for *Outreach Services* are designed to ensure that agencies:

1. Reduce the number of clients who know their status but are not currently engaged in care;
2. Reduce barriers experienced by out-of-care clients in accessing HIV related medical care; and
3. Reduce the number of clients who remain lost-to-care.

	STANDARD	MEASURE
23.1	Providers employ outreach workers who demonstrate the ability to explain to potential clients the benefits of: • Medical care for persons living with HIV; • Psychosocial support services; • The system of care for HIV positive individuals in the Indianapolis TGA; and • The available resources in the Indianapolis TGA, including RWSP services.	• Documentation is present in personnel files and available for review.

23.2	Providers employ outreach workers who demonstrate knowledge of and receive on-going training in: • Cultural and linguistic competencies; and • Conducting activities at times and in venues where there is a high probability that individuals with HIV infection will be reached.	• Documentation is present in personnel files and available for review.
23.3	Providers establish and maintain contacts with HIV testing sites, hospitals, substance abuse centers, case management agencies, and other points of entry into the HIV care system, as well as with other sources for the discovery of new clients.	• Condition is confirmed by review of written memoranda of understanding with key points of entry into care to facilitate access to care. • Condition is confirmed by review of documentation of in-coming referrals for service from key points of entry.
23.4	Providers target populations known to be at disproportionate risk for HIV infection, communities whose residents have disproportionate risk, and establishments frequented by individuals exhibiting high-risk behaviors.	• Condition is confirmed by review of applicable documentation in service records. – Documentation is quantifiable and sufficient for program reporting and evaluation of effectiveness of program design, implementation, and targeted areas and populations.
23.5	Providers adhere to grantee-approved protocols for linking positive clients into care consistent with the *Procedure for the Notification of All Newly Diagnosed HIV* policy established by ISDH which requires providers to: • Contact the chosen HIV Care Coordination site (key point of entry into care) while with the client to schedule an appointment or, if after hours, to follow-up with the care site within two days after Release of Information has been sent; • Send a Release of Information signed by the client to the chosen care site; and • Follow-up with the care site within ten working days of the original encounter to determine the success of the referral.	• Written policies are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review. • Condition is confirmed by review of written memoranda of understanding with key points of entry into care to facilitate access to care. • Condition is confirmed by review of applicable documentation in service records. – Documentation of linkage to care is sufficient to report in CareWare the outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and known to have entered care.

23.6	Providers follow-up directly with clients when a referral has been determined to be unsuccessful and at least three "good faith" attempts are made to contact the client.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.
23.7	Providers collect data on the total number of HIV positive contacts made and the number who successfully entered care as a result of the intervention.	• Referral tracking forms are complete, on file, and available for review.
23.8	Providers record the reason(s) identified by the client as leading to their disengagement from care prior to the intervention.	• Referral tracking forms are complete, on file, and available for review.
23.9	Providers coordinate with existing HIV prevention efforts and programs to avoid duplication and provide outreach services only where existing federal, state, and local funds are not adequate (ensuring that RWSP funds supplement and do not supplant existing funds).	• Written tracking and billing procedures are current, on file, and available for review. • Written grantee approval of protocol is current, on file, and available for review. • Condition is confirmed by review of applicable documentation of financial and program data demonstrating that outreach funds are **not** being used for actual HIV counseling and testing, to support broad-scope awareness activities that target the general public (instead of specific populations and communities with high rates of HIV infection), or to duplicate HIV prevention outreach efforts.

24. Psychosocial Support Services (including pastoral care and counseling)

Psychosocial Support Services include individual support and counseling activities designed to address behavioral and physical health concerns. Activities may include bereavement counseling, caregiver support, child abuse and neglect counseling, nutrition counseling, and pastoral care. Caregiver support may be provided to any person (regardless of HIV status) who functions as a caregiver for an enrolled client. Nutrition counseling does not include the provision of nutritional supplements and, under this category, would not be provided by a registered dietician. Though allowable by HRSA, the RWSP does not offer this service in a group context.

These standards for *Psychosocial Support Services* are designed to ensure that:

1. Prompt referrals are made for any clients with needs beyond the scope of the *Psychosocial Support Services* category or the demonstrated expertise of the service provider (e.g., medical concerns, mental illness, addiction issues, suicidal ideation, or homicidal threats);
2. Services promote client access to and maintenance in primary HIV-related medical care; and
3. Outcomes of *Psychosocial Support Services* are measured and documented.

	STANDARD	MEASURE
24.1	Services are provided by a licensed or accredited provider whenever such licensure or accreditation is required.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review**.**
24.2	*Psychosocial Support Services* funds are not used for social or recreational activities or for gym memberships but are used only to support eligible activities, including: • Support and counseling activities; • Child abuse and neglect counseling; • Pastoral care and counseling; • Caregiver support; • Bereavement counseling; and • Nutrition counseling provided by a non-registered dietitian.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
24.3	Pastoral care services, when provided, are: • Provided by an institutional pastoral care program; • Provided by a licensed or accredited provider wherever such licensure or accreditation is required; • Available to all individuals eligible to receive RWSP services, regardless of their religious denominational affiliation.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review**.** • Condition is confirmed by review of applicable documentation in service records.

24.4	Staff and volunteers providing services are trained in core competencies, including: • Active listening; • One-on-one support skills; and • Conflict de-escalation and resolution.	• Documentation is present in personnel files and available for review. – Documentation includes evidence that staff and volunteers have completed the appropriate training prior to the provision of service.
24.5	Staff and volunteers have a demonstrated expertise in the applicable subject area.	• Documentation is present in personnel files and available for review. – Documentation includes evidence that staff and volunteers have adequate training, education, or experience in the applicable subject area.
24.6	Designated mental health and substance abuse professionals are available for staff consultation as needed.	• Condition is confirmed by review of written memoranda of understanding (or similar arrangement) with mental health and substance abuse consultants.
24.7	Providers screen new clients at intake (and re-screen existing clients annually) to evaluate, at minimum, the following: • The client's support system; • The client's psychosocial support needs; • The client's history of accessing primary care and other services; and • Any barriers to access experienced by the client, noting psychosocial support barriers in particular.	• Condition is confirmed by review of applicable documentation in service records.
24.8	Providers make appropriate referrals.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that referrals were made as needs were identified.
24.9	Provider's follow-up with clients who miss scheduled visits within one working day to address barriers and reschedule that appointment, and at least three "good faith" attempts are made to contact the client.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of attempts to contact client in signed, dated progress notes.

25. Referral to Health Care and Supportive Services

Referral to Health Care and Supportive Services includes activities that direct a client to a needed core or support service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of *Outpatient and Ambulatory Medical Care* or any type of *Case Management* service.

Activities may include benefits and entitlement counseling and referrals to assist 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 Manufacturers' Patient Assistance Programs, other State or local health care and supportive services, or health insurance Marketplace plans).

These standards for *Referral to Health Care and Supportive Services* are designed to ensure that agencies:

1. Provide personalized referral services based on the client's needs; and
2. Ensure that services are not duplicative with other available resources.

	STANDARD	MEASURE
25.1	Services are provided to RWSP clients in person or through other forms of direct communication.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the date of service and method of communication with the client.
25.2	Providers counsel RSWP clients regarding benefits and entitlements and provide referrals for the same in accordance with the client's stated needs and HRSA requirements.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a description of the benefits and counseling activities provided, as well as the number and type of referrals provided.
25.3	Services are not offered where similar referral services are provided as a part of *Outpatient and Ambulatory Medical Care* or either type of *Case Management* service	• Written policies are current, on file, and available for review.
25.4	When services are offered in the context of an outreach program, documentation of such services is maintained separately.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes the referral context (e.g., outreach program).
25.5	Provider's follow-up directly with clients within ten working days to determine the success of the referral, and at least three "good faith" attempts are made to contact the client.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records.

26. Rehabilitation Services

Rehabilitation Services are intended to improve or maintain a client's quality of life and optimal capacity for self-care are provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care, and include physical and occupational therapy, speech pathology services, and low-vision training.

These standards for *Rehabilitation Services* are designed to ensure that agencies:

1. Comply with state and local laws, including licensing and authorization requirements, for rehabilitation service providers; and
2. Deliver services only after the development of a comprehensive care plan.

	STANDARD	MEASURE
26.1	Services are provided by a licensed or authorized professional.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review**.**
26.2	Providers work to improve or maintain a client's quality of life and optimal capacity for self-care.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written care plans with appropriate content and signatures and which are consistently prepared and updated as needed.
26.3	All services are provided based on a written, individualized plan of care signed by the client and the service provider.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written care plans with appropriate content and signatures and which are consistently prepared and updated as needed.
26.4	Care plans specify the types of services needed and the quantity and duration of services.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written care plans with appropriate content and signatures which are consistently prepared and updated as needed and which specify the types of services needed and the quantity and duration of such services.

26.5	Services are limited to allowable activities offered in an outpatient setting, including physical and occupational therapy, speech pathology services, and low-vision training.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes the types of rehabilitation services provided (physical and occupational therapy, speech pathology, or low- vision training), as well as the date, duration, location of services, and type of facility. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

27. Respite Care

Respite Care includes non-medical assistance for an HIV-infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV. Funds may be used to support informal home-based respite care provided that issues of liability are addressed, any payment made is reimbursement for actual costs, and no cash payments are made to clients or primary caregivers.

These standards for *Respite Care* are designed to ensure that agencies:

- Deliver services in a safe environment that limits liability for the client, provider, and the RWSP.

	STANDARD	MEASURE
27.1	Providers offer non-medical assistance to temporarily relieve a primary caregiver of the day-to-day care responsibilities for a RWSP client.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of client eligibility.
27.2	Assistance is provided either in a community setting or a home-based setting.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes service location information, as well as the date and duration of service.
27.3	Assistance excludes payment for a client's gym membership and any off-premises social and recreational activities but does include recreational and social activities when provided in a licensed or certified provider setting (including drop-in centers within HIV ambulatory medical services or satellite facilities).	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes service location information, as well as the date and duration of service. – Documentation of all applicable licensures or certifications is available for review. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
27.4	Respite care is delivered by a non-professional only after: • Liability issues have been addressed; • A mechanism for payments has been developed that does not involve direct cash payment to clients or primary caregivers; and • Payments provide reimbursement for actual costs without over payment, especially if using vouchers or gift cards.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence that no cash payments have been made to the client or primary caregiver and that the payment is reimbursement for actual costs. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

27.5	When an agency arranges for services to be provided informally by a non-professional, liability release forms (designed to protect the client, provider, and the RWSP) are signed by the client prior to the provision of service.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes a signed liability release forms obtained that protect the client, provider, and the RWSP.

28. Substance Abuse Treatment – Residential

Residential *Substance Abuse Treatment* addresses substance abuse problems (including alcohol, legal prescriptions, and illegal drugs) in a short-term residential health service setting.

Services include screening, assessment, diagnosis, and treatment of substance use disorders. Allowable activities include pre-treatment ("recovery readiness") programs, harm reduction, behavioral health counseling associated with substance use disorder, medication assisted therapy, neuro-psychiatric pharmaceuticals, relapse prevention services, acupuncture, and detoxification.

Services are provided by or under the supervision of a physician or other qualified personnel with appropriate and valid licensure and certification by the State of Indiana. They are 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 RWSP, and they must be provided in accordance with a written treatment plan.

Detoxification must be provided in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital). Limited acupuncture services are permitted as part of a substance use disorder treatment program funded under the RWSP when included in a documented plan and when provided by practitioners certified or licensed in the State of Indiana.

These standards for residential *Substance Abuse Treatment* are designed to ensure that agencies:

1. Comply with state and local laws, including licensing and certification requirements, for residential substance abuse treatment providers; and
2. Deliver services only after the development of a written treatment plan.

	STANDARD	MEASURE
28.1	Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the State of Indiana.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review. – Documentation includes evidence of supervision by a physician or other qualified personnel, if necessary.
28.2	Services are provided in accordance with a written referral and treatment plan.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes written referral and treatment plans with appropriate content and signatures which are consistently prepared and updated as needed and which specify the types of services needed and the quantity, frequency, and modality of treatment services

28.3	Services and progress are closely monitored by the service provider.	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes evidence of regular monitoring and assessment of client progress.
28.4	Services are provided only in short-term residential settings.	• Written policies are current, on file, and available for review. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes service location information (limited to short- term residential settings) and the date treatment begins and ends.
28.5	Acupuncture services are provided in the context of residential *Substance Abuse Treatment* services when they are: • Within the per-client financial cap defined by the RWSP; • Preceded by a written referral from the client's RWSP outpatient substance abuse treatment provider; • Included in a documented plan as part of a substance use disorder treatment program funded under the RWSP; and • Performed by a provider with appropriate State license and certification.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review. • Condition is confirmed by review of applicable documentation in service records. – Documentation includes financial cap information, written referral from the client's RWSP outpatient substance abuse treatment provider, written treatment plan, and the quantity of acupuncture services provided.

29. Treatment Adherence Counseling

Treatment Adherence Counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV treatments, provided by non-medical personnel outside of the *Medical Case Management* and clinical setting.

These standards for residential *Treatment Adherence Counseling* are designed to ensure that:

- Services are provided by qualified personnel in a non-clinical setting.

	STANDARD	MEASURE
29.1	Providers have completed a standardized "Red Cross-equivalent" *HIV 101* training course.	• Documentation is present in personnel files and available for review.
29.2	Providers have received specialized training in order to effectively ascertain a client's readiness for initiating or adhering to treatment.	• Documentation is present in personnel files and available for review.
29.3	Providers have been training to use Motivational Interviewing or similar techniques to affect behavior change in clients.	• Documentation is present in personnel files and available for review.
29.4	Providers are not medical personnel and are not *Medical Case Management* staff.	• Written policies are current, on file, and available for review. • Documentation is present in personnel files and available for review. • Condition is confirmed by review of applicable documentation in service records.
29.5	Services are provided outside of the *Medical Case Management* and clinical settings	• Condition is confirmed by review of applicable documentation in service records. – Documentation includes service location information.

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