Standards of Care for HIV Services

2019-2022

For Case Management (Medical and non-medical), Dental Services, HIV Drug and insurance Assistance (VMAP), Medical Nutrition Therapy, Mental Health Services, Psychosocial Support, Outpatient Ambulatory Services, and Emergency Financial Assistance.

Table of Contents

Introduction

The standards of care in this document were developed by the Vermont Department of Health Ryan White Care Program for services funded through the HIV/STD/Hepatitis Program for People living with Diagnosed HIV Infection. The standards are based upon guidance established by the Ryan White CARE Act and administered through the Health Resources and Services Administration (HRSA). The 2019 standards were updated with the involvement of the Vermont Department of Health's Community Advisory Committee (CAG). These standards will be updated/reviewed annually, or as new service categories are added.

Section I of the Standards of Care applies to all funded programs and is known as the **Universal Standards of Care**. Each section begins with the objectives of the specific group of standards and is followed by specific standards and measures. The standards of care in Section I apply to all programs funded by the Vermont Department of Health for any of the HIV services listed below.

- Case Management (Medical & non-medical)
- Dental Services
- HIV Drug and Insurance Assistance – Vermont Medication Assistance Program (VMAP)
- Medical Nutrition Therapy
- Mental Health Services
- Outpatient Ambulatory Medical Care
- Psychosocial Support
- Emergency Financial Assistance (EFA)

In addition to these universal standards, **Section II** contains additional standards that apply to each specific service category. These **Service-specific Standards of Care** apply to components of service delivery that vary by service category. Providers of these services must comply with the Universal Standards in Section I, as well as the Service-Specific Standards in Section II.

Section I
Universal Service Standards

Section I: Universal Service Standards

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by Ryan White Part B (through the Vermont Department of Health). **Providers may exceed these standards**. Standard forms have been created for all service categories and must be used. Modifications may not be made unless prior approval is obtained.

The objectives of the universal service standards are to help achieve the goals of each service type by ensuring that programs:

- have policies and procedures in place to protect clients' rights and ensure quality of care;
- provide clients with access to the highest quality services through experienced, trained and, when appropriate, licensed staff;
- provide services that are culturally and linguistically appropriate;
- comply with federal and state requirements/regulations;
- guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- comprehensively inform clients of services, establish client eligibility, and collect client information through an intake process;
- effectively assess client needs and encourage informed and active client participation;
- address client needs effectively through coordination of care with appropriate providers and referrals to needed services; and
- are accessible to all people living with diagnosed HIV infection in Vermont who meet eligibility requirements.

1.0 Agency Policies and Procedures

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

- guarantee client confidentiality, ensure quality care, and provide a fair process to address clients' grievances;
- ensure client and staff safety and well-being;
- facilitate communication and service delivery; and
- ensure that agencies comply with appropriate state and federal regulations.

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

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, or use of services. Each agency will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will use the ***Release of Information Form*** created by the health department, describing under what circumstances client information can be released. Clients shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year.

Included in the release, is a ***File Review Consent*** in which clients grant permission for the Vermont Department of Health and the Health Resources and Services Administration (HRSA) to review client files on site during site visits. For clients who choose not to sign the client consent form, agencies will be required to redact all individually identified information in the file for the review to still occur.

As part of the intake process (see *Section 5.0*), information requested on the ***Ryan White Part B Intake Form*** must be collected for every client, maintained in the client's file, and entered into CareWare. Agencies can choose whether they want to keep electronic, paper or both type of files.

A provider agency's **grievance procedure** ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the client may appeal the decision if the client's grievance is not settled to his/her satisfaction within the provider agency, including reporting to the health department.

1.0 Agency Policies and Procedures			
	Standard		**Measure**
1.1	Client confidentiality policy exists.	1.1	Written policy on file at provider agency.
1.2	Grievance procedure exists.	1.2	Written procedure on file at provider agency.
1.3	Agency has eligibility requirements for services, in written form, available upon request.	1.3	Written policy on file at provider agency.
1.4	A complete file for each client exists. All client files are stored in a secure and confidential location, and electronic client files are protected from unauthorized use.	1.4	Files stored in a locked file or cabinet with access limited to appropriate personnel. Electronic files are password protected with access limited to appropriate personnel. Paper copies of all required forms that must be signed by the client and/or provider are in every client's file. Files for discharged clients are clearly marked.
1.5	Client's consent for release of information is determined.	1.5	An up-to-date ***Release of Information Form*** exists, signed and dated by the client.
1.7	Agency maintains progress notes of all communication between provider and client. Progress notes indicate type of contact, service provided, date and referrals that link clients to needed services. Notes are in chronological order.	1.7	Progress notes maintained in individual client files.
1.8	Crisis management policy exists that addresses, at a minimum, infection control (e.g., needle sticks), mental health crises, and dangerous behaviors by clients or staff.	1.8	Written policy on file at provider agency.
1.9	Policy on universal precautions exists; staff members are trained in universal precautions.	1.9	Written policy on file at provider agency; documentation of staff training in personnel file.
1.10	Policy and procedures exist for handling medical emergencies.	1.10	Written policy and procedures on file and posted in visible location at site.

1.11	Agency complies with ADA criteria for programmatic accessibility. In the case of programs with multiple sites offering identical services, at least one of the sites is in compliance with relevant ADA criteria.	1.11	Site visit conducted by funder.
1.12	Agency complies with all applicable state and federal workplace and safety laws and regulations.	1.12	Signed confirmation of compliance with applicable regulations on file.

2.0 Client Rights and Responsibilities

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

- ensure that services are available to all eligible clients;
- ensure that services are accessible for clients;
- inform clients of their rights and responsibilities as consumers of HIV services.

HIV services funded by the Vermont Department of Health (VDH) must be available to all clients who meet eligibility requirements and must be easily accessible.

Providers of HIV services funded by VDH must provide all clients with a ***Client Rights and Responsibilities*** document that includes, at a minimum, the agency's confidentiality policy, the agency's expectations of the client, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a due process for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a client about unacceptable or inappropriate behaviors or actions and allowing the client to respond before discharging them from services. Some behaviors may result in immediate discharge.

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

2.0 Client Rights and Responsibilities	
Standard	**Measure**
2.1 Services are available to any individual who meets program eligibility requirements.	2.1 Written eligibility requirements on file; client utilization data made available to funder.
2.2 Services are accessible to clients.	2.2 Site visit conducted by funder that includes, but is not limited to, review of hours of operation, location, proximity to transportation, and other accessibility factors.
2.3 Program provides each client a copy of a ***Client Rights and Responsibilities*** document that informs him/her of the following: • the agency's client confidentiality policy; • the agency's expectations of the client as a consumer of services; • the client's right to file a grievance; • the client's right to receive no-cost interpreter services;	2.3 Copy of ***Clients Rights and Responsibilities*** document is given to client; a copy of the form (or a signature/acknowledgement page) is signed by client and kept in client file.

• the reasons for which a client may be discharged from services, including a due process for involuntary discharge. 2.4 Clients have the right to access their file.	2.4 Copy of agency's Client File Access policy is signed by client and kept in client file.

3.0 Personnel

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

- provide clients with access to the highest quality of care through qualified staff;
- inform staff of their job responsibilities; and
- support staff with training and supervision to enable them to perform their jobs well.

All staff and supervisors will be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. At a minimum, all staff should be able to provide appropriate care to clients infected/affected by HIV, be able to complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). Clinical staff must be licensed or registered as required for the services they provide. **See Section II; Service Specific Standards for additional competencies for some service categories.**

3.0 Personnel	
Standard	**Measure**
3.1 Staff members have the minimum qualifications expected for their job position, as well as other experience related to the position and the communities served.	3.1 Résumé in personnel file meeting the minimum requirements of the job description.
3.2 Staff members are licensed as necessary to provide services.	3.2 Copy of license or other documentation in personnel file.
3.3 Staff and supervisors know the requirements of their job description and the service elements of the program.	3.3 Documentation in personnel file that each staff members received job description.
3.4 Newly hired staff are oriented within 6 weeks, and begin initial training within 3 months of being hired. Ongoing training continues throughout staff's tenure.	3.4 Documentation in personnel file of (a) completed orientation within 6 weeks of date of hire; (b) commencement of initial training within 3 months of date of hire; and (c) ongoing trainings.

4.0 Cultural and Linguistic Competence

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

Culturally and linguistically appropriate services are services that:

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

As part of the on-going process of building cultural and linguistic competence, providers will be required to participate in the health department's Cultural Competence Training when initially hired.

4.0 Cultural and Linguistic Competence			
	Standard		**Measure**
4.1	All staff receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.	4.1	All staff members receive appropriate training within the first year of employment and periodically thereafter as needed. Copies of training verification in personnel file.
4.2	Programs' physical environment and facilities are welcoming and comfortable for the populations served.	4.2	Funder site visit.
4.3	All programs ensure access to services for clients with limited English skills in one of the following ways (listed in order of preference): • Bilingual staff who can communicate directly with clients in preferred language; • Face-to face interpretation provided by qualified staff, contract interpreters, or volunteer interpreters; • Telephone interpreter services (for emergency needs or for infrequently encountered languages); or	4.3	Programs document access to services for clients with limited English skills through the following: • For bilingual staff, résumés on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting; • Copy of certifications on file for contract or volunteer interpreters; • Listings/directories on file for telephone interpreter services; or

4.4	Clients are informed of their right to obtain no-cost interpreter services in their preferred language, including ASL.	4.4	***Client Rights and Responsibilities*** document includes notice of right to obtain no-cost interpreter services
4.5	Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider obtains a written and signed consent in the client's language. Family member or friend must be over the age of 18.	4.5	Family/friend interpretation consent form signed by client and maintained in client file.
4.6	Clients have access to linguistically appropriate signage and educational materials.	4.6	Programs provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc.)

5.0 Intake and Eligibility

The objectives of the standards for the intake process are to:

- assess client's immediate needs;
- inform the client of the services available and what the client can expect if s/he were to enroll;
- establish the client's eligibility for services, including HIV status and other criteria;
- establish whether the client wishes to enroll in a range of services or is interested only in a discrete service offered by the provider agency;
- explain the agency policies and procedures;
- collect required state/federal client data for reporting purposes;
- collect basic client information to facilitate client identification and client follow up; and
- begin to establish a trusting client relationship.

All clients who request or are referred to HIV services will participate in the **intake process**. Intake is conducted by an appropriately trained program staff or intake worker. The intake worker will review client rights and responsibilities, explain the program and services to the client, explain the agency's confidentiality and grievance policies to the client, assess the client's immediate service needs, and secure permission from the client to release information (if there is an immediate need to release information). The ***Ryan White Intake Form*** must be used and will be supplied by the health department. Any modifications to the intake form or additional forms created by the agency to use during intake, must receive prior approval by the health department.

Intake is considered complete if the following have been accomplished: (1) the client's HIV positive status has been verified and documented; (2) the Ryan White Intake and Assessment Form has been completed; (3) the client's income has been verified and documented; (4) the client's residency status has been verified and documented; and (5) the information below (at a minimum) has been obtained from the client:

- name, address, DOB, race/ethnicity, phone, and email (if available);
- preferred method of communication (e.g., phone, email, or mail);
- emergency contact information;
- preferred language of communication;
- enrollment in other HIV/ services including case management and other HIV/ or social services;
- primary reasons and need for seeking services at agency.
- housing status

A client who chooses to enroll in services and who is eligible will be assigned a staff case manager to begin receiving appropriate services. Referrals for other appropriate services will be made if ineligible. The intake process will begin within five business days of the first client contact with the agency. Ideally, the client intake process should be completed as quickly as possible; however, recognizing that clients may not have on hand the required documentation (e.g., documentation of HIV status), the intake process should be completed within 30 days of beginning intake.

5.0 Intake and Eligibility	
Standard	**Measure**
5.1 Intake process is completed within 30 days of initial contact with client and documents client's contact information (including his/her emergency contact's name and phone number) and assesses his/her immediate service needs and connection to primary care and other services.	5.1 Completed intake, dated no more than 30 days after initial contact, in client's file.
5.2 For providers of services other than case management, client is asked about connection to case management. If client is not connected to case management, provider facilitates a supported referral to case management services.	5.2 Documentation in client's file.
5.3 To determine minimum eligibility for services, client's HIV-positive status, income and VT residency is verified if client chooses to enroll.	5.3 Physician's note or laboratory test in client's file documenting that client is HIV- positive, income and VT residency documentation.

6.0 Assessment and Service Plan

The objectives of the standards for assessment and service plan are to:

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

Assessment
All providers must assess the client's needs for the provider's service(s) to develop an appropriate service plan.

Service assessments include an assessment of all issues that may affect the need for the provider service. The assessment is a cooperative and interactive endeavor between the staff and the client. The client will be the primary source of information. However, with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information, if the client grants permission to access these sources. The assessment should be conducted face-to-face within 30 days of intake, with accommodations for clients who cannot attend the appointment at the provider agency for various reasons (ex: transportation, too ill, etc.). The ***Ryan White Intake Form*** must be used to conduct the assessment.

It is the responsibility of the staff to reassess the client's needs with the client as his/her needs change. The reassessment should be done as needed, but no less than once every twelve (12) months [**exception:** MCM must reassess at least every 6 months]. If a client's income, housing status, or insurance status/resource has changed since assessment or the most recent reassessment, agencies must ensure that the data on the Ryan White Intake form is updated accordingly. The staff member is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's well-being. Staff members must comply with established agency confidentiality policies (see Standard 1.1) and release form when engaging in information and coordination activities.

Individual Service Plan (ISP)
The purpose of the **Individual Service Plan (ISP)** is to guide the provider and client in their collaborative effort to deliver high quality care corresponding to the client's level of need. It should include short-term and long-term goals, based upon the needs identified in the assessment, and action steps needed to address each goal. The ISP should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up. Agencies must use the ***ISP*** form developed by the health department.

As with the assessment process, service planning is an on-going process. It is the responsibility of the staff to review and revise a client's ISP as needed, but not less than once every twelve (12) months [6 months for MCM].
As part of the ISP, programs must ensure the coordination of services. Coordination of services requires identification of other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff will act as a liaison among clients, caregivers, and

other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals.

6.0 Assessment and Service Plan	
Standard	**Measure**
6.1 Within 30 days of client contact, assessment is conducted of client's need for particular service.	6.1 Completed assessment form in the client file.
6.2 Within 30 days of client contact, ISP is developed collaboratively with the client that identifies goals and objectives, resources to address client's needs, and a timeline.	6.2 Completed ISP in client file signed by the client and staff person.
6.3 Reassessment of the client's needs is conducted as needed, but not less than once every twelve (12) months [6 months for MCM].	6.3 Documentation of reassessment in the client files (e.g., progress notes, update notes on the initial assessment, or new assessment form).
6.4 Service plan is reviewed and revised as needed, but not less than once every twelve (12) months [6 months for MCM].	6.4 Documentation of ISP review/revision in client's file (e.g., progress notes, update notes on initial ISP, or new ISP). Updated ISP shall be signed by client, staff person, and supervisor.
6.5 Program staff identify and communicate as appropriate (with documented consent of client) with other service providers to support coordination and delivery of high quality care and to prevent duplication of services.	6.5 Documentation in client file of other staff within the agency or at another agency with whom the client may be working.

7.0 Transition and Discharge

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

- ensure a smooth transition for clients who no longer want or need services at the provider agency;
- maintain contact with active clients and identify inactive clients;
- assist provider agencies in more easily monitoring caseload; and
- plan after-care and re-entry into service.

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

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

- client dies;
- client requests a discharge;
- client's needs change and (s)he would be better served through services at another provider agency;
- client's actions put the agency, service provider, or other clients at risk;
- client sells or exchanges emergency assistance, child care, or transportation vouchers for cash or other resource for which the assistance is not intended;
- client moves/relocates out of the service area; or
- agency is unable to reach a client, after repeated attempts, for a period of 12 months [6 months for MCM]. Prior to terminating client, agency is required to reach out to DIS at the health department to discuss the case.

7.0 Transition and Discharge	
Standard	**Measure**
7.1 Agency has a transition and discharge procedure in place that is implemented for clients leaving or discharged from services for any of the reasons listed in the narrative above.	7.1 Completed transition/discharge summary form on file, signed by client (if possible) and supervisor. Summary form should include: • reason for discharge; and • a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
7.2 Agency has a due process policy in place for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	7.2 Due process policy on file as part of transition and discharge procedure; due process policy described in the ***Client Rights and Responsibilities*** document
7.3 Agency has a process for maintaining communication with clients who are active and identifying those who are inactive.	7.3 Documentation of agency process for maintaining communication with active clients and identifying inactive clients. Documentation the health department DIS were consulted prior to termination.
7.4 Agency provides clients with referral information to other services, as appropriate.	7.4 Resource directories or other material on HIV related services are on file and provided to clients.

Section II
Service-Specific Standards

Section II: Service-Specific Standards

In addition to the Universal Standards of Care, providers of services must also meet additional standards that are specific to certain services. This section contains standards of care specific to the following services:

- Case Management (Medical and non-medical)
- Dental Services
- HIV Drug Assistance
- Medical Nutrition Therapy
- Mental Health Services
- Outpatient Ambulatory Care
- Psychosocial Support
- Emergency Financial Assistance

If you are a provider of any of the above services, your program must meet both the Universal and Service Specific Standards of Care.

Case Management (Medical and Non-Medical)

Case Management Service Definition
HIV case management consists of client-centered services that link clients with health care and psychosocial support services in a manner that ensures timely, coordinated access to appropriate levels of care commensurate with the client's needs. Activities include assessment of the client's needs and personal support systems; development of a comprehensive individualized service plan that includes access to public and private benefits, as applicable; coordination of the services required to implement the plan; monitoring of the client's progress to assess the efficacy of the plan; and periodic reevaluation and revision of the plan as the needs of the client change over time. Case management also promotes the prevention of HIV transmission, sexually transmitted infections (STIs), and viral hepatitis. Additionally, medical case management includes the coordination and follow-up of medical treatment and the provision of treatment adherence counseling.

The ultimate goal of case management is to help clients enter into and remain in medical care. In the process, programs must facilitate each client's progress toward self-sufficiency.

The standards below apply to both Medical Case Management and non-Medical Case Management unless otherwise specified.

Case Management Standards of Care
The overall objectives of the Case Management standards of care are to:

- provide the highest quality of care through experienced and trained case managers;
- gather information to assess and determine each client's needs; and
- develop and implement a service plan.

The service specific standards of care for **Case Management** provide additional requirements on the following components of service provision:

A. Agency Policies and Procedures
B. Competencies
C. Assessment and Service Planning

Case Management providers are expected to comply with the Universal Standards of Care, as well as these additional standards (unless specifically noted otherwise).

EXCLUSION: Case Management; non-medical providers *are not required* to collect CD4 and/or viral load data (Exception: acuity level 3 & 4 clients must have documented VL and CD4 results at least annually in the file). However, in order to provide comprehensive case management; non-medical services, it is recommended that agencies develop a mechanism to collect CD4 and viral load data on every client at least once in a 12-month period. This can include client attestation of lab results.

A. Agency Policies and Procedures

The objective of the agency policies and procedures standards for **Case Management** is to ensure that case managers have appropriate caseloads.

A. Agency Policies and Procedures		Case Management	
Standard		**Measure**	
A.1	Case managers (1.0 FTE) have a minimum of twenty-five (25) active clients. (*Excludes medical case management)*	A.1	Files exist for at least twenty-five (25) active clients for each 1.0 FTE case manager. Written justification for any caseload size of less than twenty-five (25) clients per 1.0 FTE case manager must be on file at the agency.
A.2	Case management supervisor conducts a file review annually to ensure that client files meet standards.	A.2	Documentation in client's file or separate location (e.g., binder).

B. Competencies

The objectives of the competencies standards for **Case Management** are to:

- provide the highest quality of care through experienced and trained case managers;
- provide case managers with quality supervision; and
- inform case managers/case management supervisors of their job responsibilities.

HIV case managers must be able to work with clients and develop a supportive relationship, enable clients to reach their self-sufficiency goals, and facilitate access to and use of available services. At a minimum, all case managers hired by provider agencies will be able to demonstrate the ability to coordinate services, information and referrals for clients in need of case management services, the ability to complete documentation as required by their position, and previous experience in the human service delivery field. All HIV case managers and case manager supervisors will be given a written job description that outlines specific minimum qualifications. Once hired, case managers must participate in the VDH case manager training within three months of being hired.

B. Competencies	**Case Management**
Standard	**Measure**
B.1 Newly hired HIV case managers have at least the following qualifications: • the ability to coordinate services, information, and referrals for clients in need of HIV related medical and support services; • the ability to complete documentation required by the case management position; and • experience and/or education consistent with the job description. • ***Medical Case Mangers:*** must be either medically credentialed or trained health care staff and operate as part of the clinical care team	B.1 Job description on file that describes minimum qualifications of standard. Résumé in personnel file meeting minimum requirements of the job description.
B.2 Newly hired or promoted HIV case manager supervisors have at least the minimum qualifications described above for case managers plus two years of case management experience or other experience relevant to the position (e.g., volunteer management).	B.2 Résumé in personnel file meeting minimum requirements of standard.
B.3 Newly hired case managers attend funder-sponsored case management training within three months of being hired (or as soon as available thereafter), as well as other trainings on risk assessment and positive prevention.	B.3 Documentation of completed training on file.

C. Assessment and Service Planning

The objectives of the assessment and service planning standards for **Case Management** are to:

- gather appropriate information from each client at regular intervals to determine and assess his/her needs; and
- develop, implement, and monitor a service plan collaboratively with each client, including action steps and a timeline for meeting his/her goals based on his/her needs.

A client has a right to a fair and comprehensive assessment of his/her medical and support service needs. The focus of the **initial assessment** is to evaluate client needs through a cooperative and interactive process involving the case manager and the client. The client will be the primary source of information, but information from other sources (e.g., family members, or medical and psychosocial providers) may be included if the client grants permission to access these sources. The initial assessment should be conducted face-to-face and at a location that is mutually acceptable to the client and the case manager (including the client's home or in the hospital if the client is too sick to travel to the agency). The assessment may occur at intake but must be completed within 30 days of intake.

The assessment form is part of the **Ryan White Intake Form** and includes an acuity scale. ***For clients who are dually enrolled in medical case management and case management services, only one intake and assessment form need to be completed***. Agencies may decide to implement a MOA in order to share data, otherwise, each agencies must complete their own intake/assessment. The MOA must be approved by the health department prior to implementation. The assessment portion address at minimum the following components:

- Basic information about the client
- Connection to medical care
- Health status
- Access to benefits
- Support systems and relationships
- Housing
- HAV & HBV vaccination status
- HCV status
- Financial and legal concerns
- Access to nutritious food
- Mental health
- Sexual health history
- prevention/partner services
- Substance use
- Overall level of need

Based on the information collected during the intake and initial assessment, the case manager will create a customized **individual service plan (ISP)** with the client. The ISP form is developed by the health department and must be used. The ISP serves as the road map for the client's progress through the HIV service system and will include measurable goals and objectives that encourage client self-sufficiency. The ISP should include specific services needed and referrals to be made including time frames and a plan for follow-up. The ISP must address harm reduction and positive prevention. ISP must be completed within 30 days of the initial intake.

Assessment and service planning are ongoing processes. It is the responsibility of the case manager to reassess a client's needs and his/her/they ISP as needed but no less than once every twelve (12) months. Medical Case Managers must reassess at least once every six (6) months.

C. Assessment and Service Planning		Case Management	
	Standard		**Measure**
C.1	Comprehensive initial assessment is completed within 30 days of intake, including: • basic information about the client; • support systems and relationships; • connection to medical care; • health status; • housing; • financial and legal concerns; • access to nutritious food; • mental health; • sexual health/positive prevention/partner services; • substance use; • overall level of need. • Hep A&B vax and HCV status	C.1	Completed case management assessment form in the client file.
C.2	Individual service plan (ISP) is completed collaboratively with the client within 60 days of intake and includes short-term and long-term goals, action steps to address each goal, specific services needed and referrals to be made, barriers and challenges, a timeline, and a plan for follow-up.	C.2	In addition to having the client's and case manager's signature, a completed ISP is reviewed, approved, and signed by the case management supervisor and stored in client's file.
C.3	Reassessment of client needs is completed as needed, and delineated by acuity scale, but not less than once every six months for medical case managers.	C.3	Documentation of reassessment in client's file.
C.4	**Medical Case Management**: Collect, track and monitor client's VL and CD4 counts at a minimum of two times per year at least 6 months apart. **Case Managers:** collect VL and CD4 at least annually for all clients with an acuity of 3 or 4	C.4	Documentation in CAREWare of VL and CD4 data.

Dental Services

Dental Services Definition
Services funded under this category are the recruitment of dentists and preventive diagnostic and therapeutic services rendered by dentists, dental hygienists, and other dental practitioners.

Dental Services Standards of Care
The overall objectives of the standards of care for Dental Services are to:

- provide access to treatment by licensed dentists;
- deliver high quality services corresponding to a client's level of need.

The service specific standards of care for **Dental Services** provide additional requirements on the following components of service provision:

A. Competencies
B. Treatment Assessment and Planning

Dental Services providers are expected to comply with the Universal Standards of Care (except as noted below), as well as these additional standards.

EXCLUSION: Dental Services providers *are not required* to adhere to Universal Standards 5.1 thru 5.3 (intake and eligibility) or 6.1 thru 6.5 (assessment and service planning), but must comply with the service specific treatment assessment and planning below (B.1 and B.2).

A. Competencies

The objective of the competencies standards for **Dental Services** is to provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

A. Competencies	Dental Services
Standard	**Measure**
A.1 Participating dentists possess appropriate license, credentials, and expertise.	A.1 Completed forms in provider's personnel files; forms contain Board of Dentistry license number.

B. Treatment Assessment and Planning

The objective of the treatment assessment and planning standards for **Dental Services** is to guide the provider in delivering high quality care corresponding to the client's level of need.

B. Treatment Assessment and Planning		Dental Services	
Standard		**Measure**	
B.1	A treatment plan is developed based upon the initial examination of the client.	B.1	Completed treatment plan in client file at the provider.
B.2	Treatment plan is reviewed and updated as deemed necessary by the dental provider.	B.2	Updated treatment plan in client file at the provider.

HIV Drug Assistance

HIV Drug Assistance Service Definition
The service funded under this category is the provision of medically prescribed pharmaceuticals used in the treatment of HIV and HIV-related conditions. This service is provided by covering either the full cost of medications, or the cost of premiums and co-pays for insurance policies with comparable pharmaceutical formularies.

HIV Drug Assistance Standards of Care
The overall objectives of the HIV Drug Assistance standards of care are to ensure that programs screen clients for eligibility for income, residency, health insurance, other sources of reimbursement, and/or other benefits.

The service specific standards of care for **HIV Drug Assistance** provide additional requirements on the following components of service provision:

A. Eligibility

HIV Drug Assistance providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

The objective of the eligibility standard for **HIV Drug Assistance** is to screen clients for eligibility for income, residency, health insurance, other sources of reimbursement, and/or other benefits.

A. Eligibility		HIV Drug Assistance	
Standard		**Measure**	
A.1	Clients are screened for eligibility for income, residency, health insurance, other sources of reimbursement, and/or other benefits every six months.	A.1	Completed documentation of initial eligibility and six month recertification screening in client's file.

Medical Nutrition Therapy

Medical Nutrition Therapy Services Definition
Services funded under this category are Registered Dietician treatment, counseling, and case consultation services provided by professional Dietician (licensed or authorized within the state). This includes ongoing treatment and/or short-term transitional services for those without access to other programs.
Medical Nutrition Therapy Services Standards of Care
The overall objectives of the Medical Nutrition Therapy Services standards of care are to:

- have policies in place to protect clients' rights;
- provide services with licensed professionals who have appropriate education and experience; and
- assess and respond appropriately to the routine and emergency nutritional needs of patients.

The service specific standards of care for **Medical Nutrition Therapy** provide additional requirements on the following components of service provision:

A. Competencies

Medical Nutrition Therapy Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objective of the competencies standard for **Medical Nutrition Therapy Services** is to provide clients with the highest quality services through experienced and trained staff.

A. Competencies	Medical Nutrition Therapy
Standard	**Measure**
A.1 Staff members are licensed, as necessary, to provide medical nutrition therapy services in Vermont.	A.1 License on file dietetics/nutrition for professionals providing medical nutrition therapy services. This typically is a Registered Dietitian.

Mental Health Services

Mental Health Services Definition
Services funded under this category are psychological and psychiatric treatment, counseling, and case consultation services provided by professional therapists (licensed or authorized within the state). This includes ongoing treatment and/or short-term transitional services for those without access to other programs.

Mental Health Services Standards of Care
The overall objectives of the Mental Health Services standards of care are to:

- have policies in place to protect clients' rights;
- provide services with licensed professionals who have appropriate education and experience; and
- assess and respond appropriately to the routine and emergency psychosocial, cognitive, and emotional needs of clients with a range of psychosocial issues.

The service specific standards of care for **Mental Health Services** provide additional requirements on the following components of service provision:

B. Competencies

Mental Health Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objective of the competencies standard for **Mental Health Services** is to provide clients with the highest quality services through experienced and trained staff.

A. Competencies	Mental Health Services
Standard	**Measure**
A.1 Staff members are licensed, as necessary, to provide mental health services in Vermont.	A.1 License on file in mental health, social work, psychology, or psychiatry for professionals providing mental health services. This typically includes psychiatrists, psychologists, and licensed clinical social workers (LICSW).

Outpatient Ambulatory Medical Care

Outpatient Ambulatory Medical Care Service Definition
Services funded under this category provide routine, non-emergency, outpatient medical care, case consultation, and patient education services.

Outpatient Ambulatory Medical Care Standards of Care
The overall objectives of the Primary Medical Care standards of care are to:

- ensure programs are licensed and accredited;
- have policies that respond to the needs of incapacitated clients and that address advance directives; and
- provide high quality services with licensed staff.

The service specific standards of care for **Outpatient Ambulatory Medical Care** provide additional requirements around the following components of service provision:

A. **Agency Licensing, Policies, and Procedures**
B. **Competencies**

Outpatient Ambulatory Medical Care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing, Policies, and Procedures

The objectives of the agency licensing, policies, and procedures standards for **Outpatient Ambulatory Medical Care** are to:

- demonstrate compliance with applicable federal and state regulations including licensing requirements for primary medical care; and
- have policies and procedures in place to protect clients' rights and ensure quality of care.

A. Agency Licensing, Policies, and Procedures		**Primary Medical Care**	
Standard		**Measure**	
A.1	Agency is licensed and accredited by appropriate state and/or federal agencies.	A.1	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or hospital license).
A.2	Agency has policies and procedures to address the needs of incapacitated clients, including policies addressing advance directives and treatment and care decisions.	A.2	Written policies on file.
A.3	Agency has written information accessible to individuals concerning their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.	A.3	Written policy on file.
A.4	Agency provides education to staff and clients about advance directives.	A.4	Written educational materials and resources made available to clients and staff, including referral information to legal advocacy services.

B. Competencies

The objective of the competencies standard for **Outpatient Ambulatory Medical Care** is to ensure that services are provided by staff who are licensed, as necessary, to provide primary medical care services.

B. Competencies	Outpatient Ambulatory Medical Care
Standard	**Measure**
B.1 Staff members are licensed, as necessary, to provide primary medical care services.	B.1 Copy of license in personnel file for each staff member. Professional diagnostic and therapeutic services are rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner.

Psychosocial Support Services

Psychosocial Support Service Definition

Psychosocial Support is the provision of various support services that help clients living with HIV maintain optimal health and increased independence through one-on-one interactions and small group settings. Activities may include, but are not limited to:

- Support and counseling activities
- Child abuse and neglect counseling
- HIV support groups
- Caregiver support
- Bereavement counseling
- Referrals
- Educational, State-wide Retreats

Services may be provided individually through Peer support or in a group setting/training.

Psychosocial Support Standards of Care

The overall objectives of Psychosocial Support are to:

- Support PLWH to achieve/maintain a high quality of life;
- Reduce barriers to care and treatment; and
- Promote engagement in medical care and adherence to treatment.

The service specific standards of care for **Psychosocial Support** provide additional requirements around the following components of service provision:

D. Agency Policies and Procedures
E. Competencies
F. Assessment and Service Planning

Psychosocial Support service providers are expected to comply with the Universal Standards of Care, as well as these additional standards (unless specifically noted otherwise).

A. Agency Policies and Procedures

The objective of the agency policies and procedures standards for **Psychosocial Support** is to ensure that case managers have appropriate caseloads.

A. Agency Policies and Procedures		Psychosocial Support	
Standard		**Measure**	
A.1	Psychosocial Social Support (1.0 FTE) have a minimum of forty-five (45) active clients. Exception: multiple individuals can make up FTE	A.1	Files exist for at least forty-five (45) active clients for each 1.0 FTE PS.
A.2	Psychosocial Social Support supervisor conducts a file review at least once every twelve (12) months to ensure that client files meet standards and eligibility for services.	A.2	Documentation in client's file (hard copy or electronic).

B. Competencies

The objectives of the competencies standards for **Psychosocial Support** are to:

- Support PLWH to achieve/maintain a high quality of life;
- Reduce barriers to care and treatment; and
- Promote engagement in medical care and adherence to treatment.

HIV PS staff must be able to work with clients and develop a supportive relationship, enable clients to reach their self-sufficiency goals, and facilitate access to and use of available services. At a minimum, all PS staff hired by provider agencies will be able to demonstrate knowledge of the HIV service delivery system in Vermont as well as other entitlement/benefits programs, the ability to provide information and referrals for clients in need of services, the ability to complete documentation as required by their position, and provide appropriate peer support. All PS staff will be given a written job description that outlines specific minimum qualifications. Once hired, PS staff must participate in the VDH Basic Training within three-six months of being hired.

B. Competencies		**Psychosocial Support**	
	Standard		**Measure**
B.1	Newly hired PS staff have at least the following qualifications: • the ability to provide information referrals for clients in need of HIV related medical and support services; • the ability to complete documentation required by the PS position; • experience and/or education consistent with the job description; and • Knowledge of the HIV service delivery system in Vermont and other entitlement/benefit programs.	B.1	Job description on file that describes minimum qualifications of standard. Résumé in personnel file meeting minimum requirements of the job description.
B.2	Ability to provide appropriate peer support	B.2	Documentation from supervisor that staff member is qualified to provide peer support.
B.3	Newly hired PS staff attend HIV Basic Training (or equivalent) within three-six months of being hired.	B.3	Documentation of completed training on file.

C. Assessment and Record Keeping

The objectives of the assessment and record keeping standards for **Psychosocial Support** are to:

- gather appropriate information from each client at regular intervals to determine and assess his/her needs

Assessment of program eligibility must be conducted every six (6) months and include review of clients income and Vermont state residence. For clients who are dually enrolled in PS and the Vermont Medication Assistance Program (VMAP), VMAP will share annual and semi-annual recertification results with the grantee. Proof of recertification every six (6) months must be kept in client's file.

C. Assessment and Service Planning		Psychosocial Support	
Standard		**Measure**	
C.1	Initial assessment (acuity scale) is completed within 30 days of intake, including: • basic information about the client; • support systems and relationships; • connection to medical care; • health status; • housing; • financial and legal concerns; • access to nutritious food; • mental health; • sexual health/positive prevention/partner services; • substance use; • overall level of need.	C.1	Completed assessment form in the client file.
C.2	Semi-Annual and Annual recertification of client's continued eligibility. Must assess client's income and Vermont residence.	C.2	Documentation of semi-annual and annual recertification in client's file.
C.3	Session notes for each encounter are required. The form is provided by VDH and must include the type of contact, duration, key activities and must be initialed and dated.	C.3	Documentation of session notes are in client's file.
C.4	Reassessment of client needs is completed as needed, but not less than once every twelve (12) months.	C.4	Documentation of reassessment in client's file.
C.5	Records of support group discussion topics and sign in sheets are maintained	C.5	Agency has documentation of group agendas and sign in sheets on file at agency.

Emergency Financial Assistance

Emergency Financial Assistance Service Definition
The Emergency Financial Assistance (EFA) Program is an emergency financial resource available to people with HIV who present an emergency need which has resulted from an unexpected occurrence or set of circumstances demanding an immediate course of action. Emergency financial assistance is the provision of short-term payments to assist with emergency expenses for essential services when other resources are not available. Funds are available to any persons diagnosed with HIV regardless of race, sex, religion, sexual orientation, marital status, and national origin.

Persons are not eligible to receive EFA funds for housing or utilities if they live in housing units that are subsidized with federal funds.

EFA is funded through Ryan White. These funds are required to be the payer of last resort. EFA Program funds are not to be used as a substitute for family, personal, employer, governmental, community, or any other means of support.

EFA funds may be assessed up to **three times** per calendar year. An individual may not receive more than **$1000** per calendar year cycle. Agencies may submit a PA for additional access for extenuating circumstances. Each PA will be handled on a case-by-case basis.

Emergency Finacial Assisatance Standards of Care
The overall objectives of EFA are to:

- Support PLWH to achieve/maintain a high quality of life;
- Reduce barriers to care and treatment; and
- Promote engagement in medical care and adherence to treatment.

The service specific standards of care for **Emergency Financial Assistance** provide additional requirements around the following components of service provision:

A. **Agency Policies and Procedures**
B. **Assessment and Record Keeping**

EFA is only available to Service Organizations who provide Case Management – Non Medical.

A. Agency Policies and Procedures

The objective of the agency policies and procedures standards for **Emergency Financial Assistance** is to ensure that EFA is administered per Ryan White guidance.

EFA provides limited one-time or short-term payments to assist the client with an emergent need for paying for essential utilities, housing, food, transportation to medical appointments, and medications.

EFA can occur as a direct payment to an agency or though a voucher program. Under no circumstance should cash payments be made directly to the client. EFA is payor of last resort, all other resources must be exhausted first.

It is the responsibility of the Case Manager to complete the EFA application and ensure all of the required documentation is collected. The CM supervisor must review and approve all EFA requests for appropriateness.

A. Agency Policies and Procedures		EFA	
Standard		**Measure**	
A.1	The Vermont Department of Health's EFA policy is signed by all clients requesting the service.	A.1	Signed policy exists in all client files.
A.2	Each request is reviewed and signed by CM supervisor	A.2	CM supervisor signature of initials are on each EFA request in client file.

C. Assessment and Record Keeping

The objectives of the assessment and record keeping standards for **Emergency Financial Assistance** are to:

- Demonstrate the need for EFA requests, proof of hardship
- Create a financial plan that will help to prevent a future occurrence

To establish the need for this service and demonstrate the emergency nature of the request, the ***EFA Application*** (developed by the health department) will need to be completed for each request. In addition to the completed application, the following document proofs will be required:

Rental assistance – assistance is provided to prevent eviction. EFA does not pay for back rent if the applicant is already evicted. No one may be legally evicted without the filing of a legal writ of eviction. Documentation is required that an applicant is in imminent danger of being evicted from their current living situation.

- Eviction notice or the documentation of the intent to evict from a legal entity; statement of back rent signed by both landlord and tenant (form included as part of application).

Mortgage Assistance – assistance is provided to avoid foreclosure. must have all three:

- Confirmation that a partial payment will be accepted by the mortgage company if the EFA request is for a partial payment;
- A copy of the payment book coupon or monthly mortgage statement verifying regular monthly mortgage payment;
- Letter of arrearage or foreclosure notice from the mortgage company

Utility Assistance - assistance is provided for connection fees, processing costs, and to avert shut off not including any penalties or fines. If shut off has already occurred, written proof of the payment arrangement with the utility company is required. If multiple utilities are in a bill (i.e. gas and electric) each utility must be listed separately on the financial request page. This does not necessarily guarantee that multiple requests will be approved. The utility bill must be in the applicant's name. Utility company bill for one-time connection fees, processing costs

- Shut off notice which includes the applicant's name and address

Pharmaceutical - assistance is provided for HIV specific medications not covered by any form of insurance and not obtainable through VMAP or pharmaceutical assistance programs. General medications for uninsurable applicants can be covered if the medication can be linked to the applicant's HIV condition.

- Prescription from a physician, physician's assistant, clinical nurse specialist, or nurse practitioner
- Invoice for the medication

Please note that EFA grants can NOT be used for the following items or services:

- Bad debt (sent to collections)
- Down payments, rent or mortgage penalty fees

- Recreational activities including trips, summer camp, movies, etc.
- Water heater
- Personal health care products
- Burial/cremation costs
- Cooking stove
- Air conditioners and refrigerators
- Routine transportation
- Automobile repair, maintenance or insurance
- Personal debt, student loans, credit cards, etc.
- Ongoing medical expenses such as medical treatment, therapy/counseling, medical equipment, drug/alcohol rehabilitation, etc.
- Personal items including furniture, clothing, bedding
- Space heaters/appliances
- Telephones or cell phones
- Moving expenses

C. Assessment and Record Keeping		EFA	
	Standard		**Measure**
C.1	• Completed EFA application with all required documentation for each EFA request.	C.1	Completed EFA application in client's file with supporting documentation.