San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

COMMON STANDARDS OF CARE

COMMON STANDARDS OF CARE

Overview and Purpose of The Common Ryan White HIV Standards of Care

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Common Standards of Care for Ryan White HIV Services is to outline required components and procedures that are common to and must be followed by all Ryan White HIV service providers in the San Francisco EMA. Common standards addressed in this document include client eligibility and consent; staffing; cultural and linguistic competency; service management and closure; monitoring and reporting; and quality assurance. These standards must be met or exceeded for all contracted Ryan White services provided in the EMA. Users should refer to service category-specific standards for more detailed and additional requirements for specific core and support service categories.

The document below consists of the following sections:

- Basic Requirements for Ryan White HIV Service Funds
- Client Eligibility for Services
- Client Consent
- Required Client Notifications
- Coordination and Referral
- Client Discharge Procedures
- Service Accessibility and Client Self-Management
- Written Agency Policies and Procedures
- Staffing Requirements and Qualifications
- Cultural and Linguistic Competency
- Facility Standards
- Service Program Monitoring and Compliance

Please note that this document is not intended to serve as a comprehensive guide to all regulations related to Ryan White HIV service delivery, nor is it a manual of all Ryan White program requirements. Instead, the Common Standards are intended to serve as an outline of key requirements and characteristics of the Ryan White system that pertain to all core and support service categories.

Basic Requirements for Ryan White HIV Service Funds:

All clients served by providers of Ryan White-funded HIV services in the San Francisco EMA shall receive services that:

- Are accessible to all persons living with HIV who qualify and meet eligibility requirements;
- Include a comprehensive intake process that establishes client eligibility; collects client background, demographic, and service information; and comprehensively informs clients regarding available services;
- Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff;
- Are culturally and linguistically competent;
- Are developed and evaluated with input from people living with HIV to ensure care is client centered;
- Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV;
- Promote continuity of care, client monitoring, and follow-up;
- Incorporate ongoing monitoring, tracking, and reporting procedures; and
- Ensure a fair process of grievance review and advocacy.

Ryan White HIV funds are intended to support the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with Ryan White funds and the overarching goal of supporting clients in accessing and remaining engaged in HIV care, treatment, and services to promote client health and well-being.

Ryan White HIV funds must **always** be considered the funding source of last resort, to be used only when all other possible sources of funding have been exhausted or are not available. Providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for eligible services are available. Providers must document client eligibility and must further demonstrate that third party reimbursement such as Medi-Cal, Medicaid, Healthy San Francisco, and pharmaceutical company discount programs are being actively pursued, wherever applicable.

Client Eligibility for Services:[1]

Confirmation of HIV Status:

At the initial certification for receipt of Ryan White HIV funds, clients must provide proof of HIV-positive status. This must consist of at least one of the following:

- 15 HIV- positive laboratory results consisting of a confirmatory HIV antibody test, a qualitative HIV detection test, or detectable viral load results. Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis

[1] Please see attached HHS Eligibility Verification Policy (2024-01) document for complete information on current HIV status, residency, and income requirements.

NOTE: *Rapid linkage to care following receipt of HIV diagnosis is a top priority and this requirement is not intended as a barrier to services. While agencies* ***must*** *have proof of HIV diagnosis and eligibility established before providing Ryan White-funded services, there is no legislative requirement for a "confirmed" HIV diagnosis prior to care being provided. This means that an initial positive HIV screening test results is sufficient to begin providing Ryan White care and services, though confirmatory testing should be ordered at the time of the first visit.*

- Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
- Diagnosis Form CDPH 8440 completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.

Proof of Residency:

Individuals seeking Ryan White HIV services must reside in either Marin, San Francisco, or San Mateo County - the 3 counties that make up the San Francisco Eligible Metropolitan Area (EMA). Unless specified by the Ryan White grantee agency, each county only provides services to residents of that county. Acceptable residency verification consists of the prospective client's name and address on one of the following:

- Current utility bill;
- Current rental or lease agreement;
- Official document such as a voter registration card, Medi-Cal beneficiary letter, recent school records, property tax receipt, unemployment document, etc.
- Current California driver's license or California Identity Card; or
- Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as their residence on agency letterhead and signed by a staff person affiliated with the service agency or clinic.
- If no other methods of verification are possible, a letter, form, or affidavit signed and dated by the client indicating that they lack a residence and have no connection to any other service provider may be provided. In this situation, a referral to assist the client in securing shelter or housing should be a priority.
- **Please see attached HHS residency verification form on page 6 of the attached HHS Eligibility Verification Policy (2024-01) document.**

Verification of Income:

Clients must provide documentation of all forms of income and must meet the income requirements established for the Ryan White HIV CARE Program. HCP financial eligibility matches the financial eligibility defined by ADAP in Health and Safety Code (HSC § 120960) (https://law.justia.com/codes/california/2005/hsc/120950-120970.html). At the time of this writing, the State of California defines Ryan White-eligible clients as being persons with modified adjusted gross income that does not

exceed 500% of current federal poverty levels based on both family size and household income. Acceptable income verification includes one of the following:

- One employer pay stub from within the last 6 months;
- 1040 Form or W-2 from the previous year;
- Signed and dated letter from a source of earned income, including the client's name, rate, and frequency of pay;
- One bank statement showing income from applicable source(s) (i.e., through direct deposit);
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) letter, or dated screenshots of client benefit program;
- Document confirming other government assistance such as Medi-Cal military/veteran pension benefits, unemployment benefits, or child support payments;
- Investment statement showing interest earned; or
- Letter of support signed and dated by an individual providing financial and other basic living support such as food, clothing, and/or shelter to the client.
- If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates zero income or attests to earned income not otherwise confirmed by the above.
- **Please see attached HHS income verification form on page 7 of the attached HHS Eligibility Verification Policy (2024-01) document.**

Verification of Insurance Status:

Clients seeking any services through Ryan White HIV programs must provide documentation of current health insurance status, if applicable. Acceptable insurance verification includes one of the following:

- Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC), Medicare ID, and private insurance coverage card, as applicable;
- Dated screenshot(s) or printouts of client insurance status verification using an official insurance screening system;
- Verification of insurance enrollment as evidenced in the client's electronic medical records system;
- Denial letter from Medi-Cal; or
- Statement signed and dated by the client indicating they are not covered by insurance. If a client is employed, the statement must include the reason the employer does not provide insurance.

Documentation of Need:

In order for providers to pay for services covered or partially covered by Medi-Cal, Denti-Cal, Medicare, private insurance, or other eligible benefits program and ensure Ryan White funding as the payer of last resort, client charts must include the following:

- A description of the need for additional medically necessary services, beyond what the client's health care coverage or other benefits provide; and
- Documentation indicating that such services are only partially covered or unavailable in a timely fashion through the client's health care coverage or other benefit

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

NOTE: *All HCP providers who provide services that overlap with Medi-Cal or Denti-Cal must be certified to receive Medi-Cal or Denti-Cal payments or be able to document efforts underway to obtain such certification.*

Screening for Service Needs / Acuity:

At the time of client intake into any Ryan White service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Referrals should be made for any necessary services that are identified but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. Referrals must be documented wherever contractually required.

Recertification:

Following intake eligibility determination, eligibility redeterminations must be conducted and documented on an **annual basis**. Agencies may elect to conduct annual eligibility redeterminations based on the client's initial eligibility determination date. Agencies may also elect to align with the California State Office of AIDS' eligibility procedures (e.g., ADAP, OA-HIPP, MPPP) by conducting eligibility redeterminations **annually, up to 45 days before the client's birthdate**. This may require two (2) eligibility determinations within the client's first year of service, as illustrated below:

Client's Birthday	Intake Eligibility Determination	First Eligibility Redetermination	Annual Eligibility Redeterminations
January 15	April 15	January 15 (9 months after intake)	Every 12 months thereafter; up to 45 days before client's birthday
April 15	April 15	April 15 (12 months after intake)	
July 15	April 15	July 15 (3 months after intake)	
October 15	April 15	October 15 (6 months after intake)	

Required recertification documentation includes the following:

- **Proof of Residence:** Continued proof of SF EMA residency must be documented. Acceptable residency verification is the same as that required for initial eligibility certification.

- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. Acceptable income verification is the same as that required for initial eligibility certification.
- **Insurance Status**: Clients must provide documentation of health insurance status. Acceptable verification is the same as that required for initial eligibility certification.
- **Screening for Service Needs / Acuity:** At least every six months, all clients must be re-assessed for service needs and acuity level. Screening can be done using the tools and/or scales of the local jurisdiction, but these tools/scales must be standardized within the jurisdiction and documented in the client chart. Services provided to that client should be adjusted according to any changes in client needs/acuity since the last assessment.

Client Consent

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

- **Agency Consent for Service:** Clients must sign a consent form indicating they consent to receiving services from the agency.
- **ARIES Consent:** Providers must obtain a completed ARIES Share Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share status.
- **HIV Care Connect Share Consent Form:** Providers funded through HIV Health Services that are using ARIES at the time of this document will transition onto HIV Care Connect (HCC) once the system goes live in approximately the Winter of 2024. The HIV Care Connect Share Consent Form must be obtained by providers who must log that form into HIV Care Connect. The consent form is valid for **15 years** from the date of first client signature. Information shared may include client demographics, contact information, medical history, and service data.

NOTE: *The current ARIES consent form must be renewed* ***once every three years*** *or whenever clients want to change their data-sharing choice. The new HIV Care Connect form must be renewed* ***every 15 years.***

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

Required Client Notifications

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

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of Ryan White services.
- **Re-engagement services** are routinely provided by the provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services.
- **After-hours or weekend options** that are available to clients during an emergency (i.e., an on-call number, answering service, or alternative contacts in other agencies).

- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable.
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance.
- **Client Rights and Responsibilities**: Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum

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

Coordination And Referral

- All Ryan White service providers must ensure incorporation of effective approaches to coordinate client care among different services and providers in the EMA and to mutually refer clients to services appropriate to their needs, including referring and linking clients to other providers when they no longer wish to receive services from a given agency.
- Providers must provide continual, appropriate referrals to any necessary HIV and non-HIV-specific services, programs, and resources needed to support client health and well-being, including non-Ryan White-funded services and services outside the specific service region as needed to meet client needs.
- Providers should track referrals both within and outside the agency to verify client linkage to needed services.
- Providers should ensure initial and ongoing staff training in all applicable client resources in their given region and maintain resource directories and other materials to facilitate staff referral to needed services.
- Providers should coordinate care with each client's identified medical or non-medical case manager, as appropriate, to ensure that case managers are aware of all services being accessed by their assigned clients.

Client Discharge Procedures

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

- Discharge from any Ryan White service may significantly impact the client's ability to receive services and remain compliant with medical care and other programs supporting health and wellness. As such, discharge from any Ryan White service must be carefully considered, with reasonable steps taken to ensure clients who need assistance in accessing care are maintained in case management programs.
- Services discharge and exit plans must be prepared for any client who: a) no longer requires a given service; b) no longer wishes to receive services from a given agency; or c) no longer wishes to receive a given Ryan White service The discharge plan should include strategies for clients to receive and obtain services from another agency or program, or to effectively and safety transition out of a given service category. This discharge plan must be developed in collaboration with the client and signed off on by both the client and provider. This requirement does not apply to short-term services that have fixed endpoints upon successful delivery or completion of services, such as emergency financial assistance or legal services.

- Client files may be closed at the agency's discretion under specific conditions, such as when a client moves out of the geographic region or EMA, has been lost to follow-up for more than 6 months, has been incarcerated for more than 6 months, or in the event of client death. Service agencies should make and document efforts to re-engage clients lost to follow-up and as appropriate refer cases to linkage and navigation services.

Service Accessibility and Client Self-Management

Ryan White services must be planned and implemented in a way that ensures an accessible environment and that promotes client self-management. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments;
- Not be restricted on the basis of age, gender identification, sexual orientation, race, ethnicity, national origin, disability, past or current health condition, ability to pay fees, housing status, language preferences, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act;
- Must be managed to achieve:
  - Accessibility
  - Effectiveness
  - Reliability
  - Timeliness
  - Appropriateness to the needs of clients
- Must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to supporting access to non-Ryan White-funded services and making available resources guides for to low-cost/free medical and support services, including those not offered as part of the Ryan White system.

Written Agency Policies and Procedures

Each Ryan White-funded agency will have an up-to-date **written policies and procedures manual** that contains information for both clients and staff regarding:

- Clients rights and responsibilities, including confidentiality;
- Client grievance policies and procedures;
- Client eligibility and admission requirements;
- Referral lists as necessary;
- Consent to share information;
- Quality assurance policies and procedures;
- Data collection procedures;
- Human resources specific policies and procedures, including annual performance reviews;
- Staff training programs and policies;
- Confidentiality policies and agreements; and
- Written staff job descriptions.

Staffing Requirements and Qualifications

Education and Experience:

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or Ryan White Standards of Care that are appropriate to that standard of care.

Staff Orientation and Training:

Initial Training: All staff providing direct services to clients, managing direct services, or making decisions regarding HIV services must complete an initial training session related to their job description and serving those with HIV. Topics must include:

- Clients rights and responsibilities, including confidentiality;
- General knowledge of HIV infection, including knowledge of transmission, care, treatment, and prevention approaches;
- Health maintenance appropriate for persons with HIV, including approaches to supporting linkage, engagement, and ongoing retention in care;
- Psychosocial issues facing persons with HIV, including experiences of past trauma and discrimination;
- Makeup of the local HIV system of care and how to support clients in navigating in and among systems and services;
- Client confidentiality and security issues;
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health;
- Local HIV data and reporting requirements for the local jurisdiction;
- Employing agency's written policies and procedures; and
- Employing agency's written human resources policies and procedures.

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

Cultural and Linguistic Competency

- The ability of Ryan White providers to recognize and respect their clients' cultural differences and complexities is profoundly important, and the impact of cultural humility and linguistic competence cannot be overstated. Providing culturally humble and linguistically competent services ensures that clients feel comfortable and safe while accessing services; that they feel respected, valued, and honored for who they are as individuals; that they do not feel judged in regard to their specific behaviors or lifestyle; that they understand and are able to fully participate in and consent to decisions regarding the services they will receive; and that their individual choices or decisions are accepted and respected by a given agencies. Culturally competent care is also critical to achieving **health equity** - the assurance that everyone can attain their highest level of health - and to eliminating **health disparities** by providing culturally

sensitive care, reducing biases, and addressing systemic barriers to healthcare access and utilization.

- Culturally aware providers will continually be able to adapt their methods of diagnosis and treatment to fit the individual's cultural context, ensuring a more personalized and effective care plan.

- For the purpose of these standards, and based on the US Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, **"culture"** is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics, including gender identification and sexuality. Ryan White agencies must strive to understand and continually improve service delivery to respond to the broadest possible range of client cultural identification in a manner that it respectful, safe, and that honors and celebrates the uniqueness and specialness of each client served.

- Ryan White agencies should strive - to the extent possible - to hire **staff and peers that are reflective of the social, demographic, cultural, and linguistic characteristics of the client populations they will serve**. At a minimum, providers should make an effort to seek out qualified staff who have **lived experience** of some or all of the issues facing their clients. At the same time, it is important to note that having staff and peers who reflect their client populations is **not** a guarantor of high-quality and culturally competent services; more significant is the ability of staff to relate respectfully and empathetically with their clients and to provide professional services that include clear expectations, prompt follow-up, and a high degree to availability.

- Ryan White providers must provide **ongoing cultural competency and cultural humility training** designed to increase the sensitivity, appropriateness, and effectiveness of services to the broadest range of populations. This training should incorporate presentations by members of diverse populations who can share personal experiences of receiving health and social services and suggest ways in which services can be enhanced to better meet the needs of each client's service group.

- Ryan White agencies should strive to acknowledge **implicit bias**, including understanding how implicit bias plays a role in service delivery inequities and how it can be addressed and countered in the context of agency service provision. For the purpose of these standards, implicit bias refers to either acknowledged or unacknowledged attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. These biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness.

- **Linguistic competence** refers to the ability to communicate effectively with clients, including those whose preferred language is not the same as the

provider's, who have low literacy skills, and/or those with disabilities. Federal and State language access laws require health care facilities that receive federal or state funding to provide competent interpretation services to limited English proficiency patients at no cost, to ensure equal and meaningful access to health care services. **Interpretation** refers to verbal communication where speech is translated from a speaker to a receiver in a language that the receiver can understand. **Translation** refers to the conversion of written material from one language to another. Ryan White agencies should ensure that staff are in place and/or that external resources are available to communicate effectively with **all** clients who seek agency services regardless of linguist background and preferences. This includes understanding **that communication manifests in a wide variety of ways - including through** language, gestures, customs, and societal norms - and that translators and interpreters risk distorting or misinterpreting clients messages if they lack culturally competent linguistic skills.

Facility Standards

Ryan White services programs must be located in physical facilities that:

- Clients rights and responsibilities, including confidentiality;
- Meet basic fire safety requirements in alignment with local, state, and federal guidelines;
- Meet criteria for American with Disabilities Act (ADA) compliance and accessibility;
- Are clean, comfortable, safe, and trauma-informed;
- Observe Occupational Safety and Health Administration (OSHA) infection control practices
- Have emergency protocols in place for health and safety-related incidents posted; and
- Are free from anticipated hazards.

Service Program Monitoring and Compliance

All Ryan White services contracts shall include language describing the specific monitoring, data entry, and data tracking requirements and procedures needed to continuously and accurately document the delivery of Ryan White services. This includes requirements for:

- Clients rights and responsibilities, including confidentiality;
- Entering client data into agency-based electronic health record systems and other client data collection and recordkeeping systems;
- Ensuring the ongoing protection and confidentiality of client data;
- Preserving and maintaining signed client consent forms;
- Entering required data into common computerized data systems for reporting purposes;
- Entering and updating basic client demographic information;

- Entering and maintaining documentation regarding client eligibility requirements; and
- Documenting required service delivery activities and components, including dates and types of client appointments, initial and updated client care plans, client service activities, and results and impacts of services delivered as required;
- Continually evaluating the overall quality, impact, and client satisfaction of services delivered; and
- Implementing continuous quality improvement mechanisms that utilize data to identify and address barriers, shortfalls, and deficiencies in programs with the goal of achieving health equity and improved quality of care.

Ryan White client files must be retained for a minimum of **10 years** following completion of services or discharge of clients.

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STANDARDS OF CARE

BENEFITS COUNSELING

BENEFITS COUNSELING STANDARDS OF CARE

Overview and Purpose of Benefits Counseling Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Benefits Counseling Standards of Care is to ensure consistency, service equity, and a high degree of quality among services provided as part of our region's Ryan White HIV continuum of care for persons living with HIV on low incomes. These minimally acceptable standards are designed to provide guidance to Benefits Counseling programs so that they are best equipped to:

- Provide benefits counseling and advocacy services to clients;
- Assist in identifying clients' needs for benefits;
- Identify and address barriers to services; and
- Support clients' access to and ongoing follow-up with primary and other supportive services.

Description of Benefits Counseling Services

Benefits Counseling Services are client-centered activities that facilitate a client's access to public/private maintenance of health, social services, and disability benefits and programs. Benefits Counseling Services work to maximize public funding by helping clients identify all available health, social services, and disability benefits supported by funding streams in addition to Ryan White funds. These services are designed to assist a client navigate care and social services systems outside of the service delivery network funded by the Ryan White Program, educate people living with HIV about public and private benefit programs, and aid in accessing and securing these benefits. Benefits Counseling encompasses the following activities or services, provided as a part of a multidisciplinary care team:

- Assessing clients' need for financial and health care benefits;
- Assisting clients in understanding and applying for public and private financial, disability, and health care benefits;
- Determining client eligibility for benefits;
- Assisting clients through the stages of applying for financial, health care, and/or disability benefits, as applicable for individual clients and agencies;
- Advocating for clients living with HIV to obtain federal disability benefits;
- Assisting clients with filing motions for reconsideration of a previous denial of benefits and filing requests for hearing of a previous denial in front of Administrative Law Judges, as applicable for individual clients and

agencies;

- Working with legal services providers to represent and advocate on client's behalf at the Appeals Councils;
- Assisting clients who need to leave work due to disability to develop a transition plan (e.g., obtaining short and long-term disability, health insurance, etc.);
- Working with clients within the cycle of disability which includes accessing benefits when they leave work and when they return to work;
- Working with clients in making informed choices which maximize their available benefits;
- Communicating client service-related needs, challenges, and barriers to case managers and other service team members;
- Assisting clients in engaging in primary medical care; and
- Assisting clients to access the full continuum of HIV care and services, as appropriate.

The table on the following page provides a partial list of health, social service, and disability benefits and programs for which clients may be eligible and for which Benefits Counseling staff provide assessment, application, enrollment, re-enrollment, and advocacy services:

ASSISTANCE CATEGORIES	SAMPLE PUBLIC AND PRIVATE ASSISTANCE PROGRAMS
HEALTH CARE	• Assisting clients in engaging in primary medical care • Patient Assistance Programs (Pharmaceutical Companies)
INSURANCE	• State Office of AIDS Health Insurance Premium Payment (OA-HIPP) • Covered California / Health Insurance Marketplace • Medicaid / Medi-Cal / San Francisco Health Plan • Medicare • Medicare Buy-in Programs • Private Insurance
FOOD AND NUTRITION	• CalFresh • Local grocery bag and home-delivered meal programs
DISABILITY	• Social Security Disability Insurance (SSDI) • State Disability Insurance • In-Home Supportive Services (IHSS) • Supplemental Security Income (SSI) • State Supplementary Payments (SSP)
UNEMPLOYMENT FINANCIAL ASSISTANCE	• Unemployment Insurance (UI) • Worker's Compensation • Ability to Pay Program (ATP) • Cal-WORKS (TANF) • General Relief / General Relief Opportunities to Work (GROW)
HOUSING	• Section 8, Housing Opportunities for People with AIDS (HOPWA) and other housing programs • Rent and Mortgage Relief programs

OTHER	• Women, Infants and Children (WIC) Program • Childcare • Entitlement programs • Other local services and programs • National Council on Aging Benefits Check Up

Units of Service:

A Dental Unit of Service is defined as:

One hour of face-to-face contact between a client and a Benefits Counselor / Client Advocate or one hour contact on behalf of the client.

Benefits Counseling Requirements:

All Benefits Counseling programs and providers must provide the key activities listed below:

Intake:

A comprehensive client intake must be provided by a trained and qualified benefits counselor or client advocate at the time of client's beginning service. At minimum, the intake must include the following elements:

- Inform client of services available;
- Obtain client consent for services and signed release for sharing information with other providers to ensure coordination of care;
- Determine client's current insurance and benefits status and immediate needs, including existing clients barriers to medical care and psychosocial services;
- Obtain required client information related to benefits and insurance eligibility and enrollment, including demographic information, income status, required documents, and other information;
- Where necessary, obtain release of information from client to allow benefits counselor /client advocate to obtain necessary medical records in order to support benefits claims; and
- Where necessary, obtain a representation form (e.g., Social Security Administration Form 1696).

Assessment:

Information gathered during the assessment process should be utilized by a trained and qualified benefits counselor or client advocate to make the following determinations and perform the following functions:

- Assess client's financial status, assets, employment status, and health insurance;
- If client was employed but is no longer able to work, review related employer benefits plan documents and employer personnel policies;
- Obtain and evaluate all information necessary to determine client eligibility for public and/or private insurance, disability, and health benefits;
- Review client's health status and obtain necessary medical records to apply for disability; and
- Develop a written action plan with clients that detail steps necessary to qualify for and apply for all benefits for which the client is eligible.

Benefits Education and Advocacy:

The trained benefits counselor or client advocate must continually inform and educate clients regarding all public and private benefits programs for which they may be eligible, while providing ongoing support to clients in applying for and obtaining benefits, including support with benefits renewals. This includes the following activities:

- Inform and discuss with client the relationship between symptoms, functional limitations, and opportunistic infections as they relate to eligibility criteria for public and private disability benefits;
- Fully inform client of public and private financial and health care benefits for which they may be eligible;
- Assist client in understanding the insurance, disability, and/or benefits application and appeal process;
- Assist client with completing appropriate forms and paperwork associated with applications for benefits to which they are entitled;
- Assist clients through the appeals process for denials of benefits and/or disability claims; and
- Provide reminders of benefits and insurance renewal deadlines and provide support in preparing and submitting benefits and insurance renewal applications and materials.

Information and Referral:

- Provide clients with accurate information on available resources and services in the San Francisco EMA;
- Provide referrals and linkages to services in the HIV continuum of care that address clients' needs as requested or indicated by client (e.g., money management services, housing, food, medical, substance use treatment, mental health services, counseling, case management services, etc.);
- Consult with case managers/care coordinators to facilitate appropriate referrals to programs and services that can successfully meet client needs; and
- Assist clients in making informed decisions on choices of available service providers and resources.

Coordination with the Multidisciplinary Client Team:

- Work closely with client case managers, money managers / representative payee providers, treatment advocates, medical providers, and other members of care team to communicate, discuss, and/or plan collaborative responses to client service related needs, challenges, and barriers.

HIV HEALTH SERVICES
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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STANDARDS OF CARE

CENTERS OF EXCELLENCE

CENTERS OF EXCELLENCE STANDARDS OF CARE

Overview and Purpose of Centers of Excellence Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Centers of Excellence Standards of Care is to ensure consistency, service equity, and a high degree of quality among services provided as part of our region's Ryan White HIV continuum of care for persons living with HIV on low incomes. These standards are not intended to promote a formula approach to the support and assistance of persons living with HIV through the Centers of Excellence (CoE) model. Rather, these optimal acceptable standards of service delivery are established to provide guidance to integrated services programs so that they are best equipped to:

- Provide a comprehensive integrated approach to care for low-income persons with HIV who have severe needs or are part of special populations;
- Provide client-centered services that respect the client's rights, values, and preferences;
- Coordinate any and all types of services and assistance to meet each client's identified needs;
- Meet the specific and complex needs of clients through a multidisciplinary, team-based approach to care;
- Provide continuity of care for PLWHA within an integrated system of services throughout the course of their infection; and
- Continually minimize client barriers to services.

Description of Centers of Excellence Services

CENTERS OF EXCELLENCE INTEGRATED SERVICES MODEL DEFINITION

The San Francisco EMA Centers of Excellence program is an integrated services model (ISM) of health and social service delivery in which all needed client services are provided and coordinated by a multidisciplinary team whose composition is tailored to the needs of specific HIV subpopulations. Centers of Excellence ensure that populations with severe needs have direct access to a comprehensive spectrum of care that is delivered seamlessly, in a culturally competent manner, and in accordance with all relevant care standards.

The goals of Centers of Excellence services include:

- Improving health outcomes and quality of life for persons with HIV who have severe needs or are from special populations;
- Providing seamless access to all needed primary care and critical support services; and
- Linking and maintaining in health care persons with HIV who are not currently in care or are at high risk of falling out of care.

Centers of Excellence programs encompass the following activities or services as part of a multidisciplinary care team:

- Providing primary health care to persons with HIV who have severe needs or are from special populations;
- Providing treatment adherence and retention services for persons at high risk of falling out of care;
- Assisting clients in maintaining the care and support they need to preserve a health and wellness; and
- Providing seamless access to a range of critical support services including as case management, treatment adherence support, peer advocacy, substance use services, and mental health services

At the time of this writing, clients with severe need are defined by the San Francisco HIV Community Planning Council as persons with HIV who meet all of the following criteria:

- Disabled with HIV or with symptomatic HIV diagnosis;
- Active substance user or person living with a diagnosed mental illness; and
- Person living in poverty, defined as having an annual federal adjusted gross income or less than 150% of Federal Poverty Level for the current calendar year.

The Planning Council has identified the following groups as special populations who face unique or disproportionate barriers to care:

- Populations with the lowest rates of viral suppression and who experience health disparities;
- Communities with linguistic or cultural barriers to care;
- Persons who are being released from incarceration in jails or prisons, or who have a recent criminal justice history; and
- Persons living with HIV age 60 or older.

Units of Service:

A unit of service within the Centers of Excellence model is based on the specific unit of service for each sub-service delivered through the multidisciplinary

program. Please Refer to the appropriate Standards of Care to determine the specific unit of service for each service category delivered through a given CoE.

Centers of Excellence Requirements:

All Centers of Excellence programs and provider must provide the key activities listed below:

Establishment and Maintenance of Collaborations:

Each agency that is part of a Centers of Excellence collaboration must have a clear understanding of the scope of its responsibilities, as well as of the CoE's overall goal and mission. In addition, all staff providing services within integrated services programs must be properly trained and credentialed, have an understanding of the scope of their job responsibilities, and have adequate staff funding to provide specific CoE services. Agencies that are funded as multi-agency collaboratives are required to develop a Multi-Agency Agreement in order to formalize the working relationship between collaborating agencies. The Multi-Agency Agreement should be negotiated and signed by the executive directors of each collaborative agency.

The following is not an exhaustive list. The Agreement should contain the following elements:

General Information:

- Goal statement of the Agreement;
- Effective dates of the Agreement and the methods for changing or discontinuing the Agreement;
- Statements acknowledging familiarity and agreement to comply with the terms of the prime contract; and
- Name, title, and signature of each organization's representative.

Program Design:

- Common mission and objectives that outline the collaboration's systems for effectively working and operating together;
- Core values and shared philosophies that include a commitment to client-centered services; and
- Agreed-upon measurable, client-centered health outcomes and data collection and reporting methodologies.

Staffing:

- Defined agreement regarding the hiring and roles and responsibilities of the Program Coordinator;
- Defined procedure for ensuring that collaborative organizations have input

into the hiring of and evaluation of staff providing services to the extent this input is compatible with labor agreements;

- Process for ensuring that key staff positions within the collaborative are filled in a timely manner; and
- Supervision and quality assurance procedures and responsibilities.

Service Delivery:

- Specific services offered, including location, schedule, and scope of work to be provided by each organization and
- Compliance with HIPAA requirements for sharing information.

Inter-Agency / Inter-Program Communication and Coordination:

- Procedure for units of service, unduplicated clients, and cost reporting;
- Procedure for dispute resolution;
- Reporting requirements and timelines that clearly define staff responsible for reporting and submitting data and timely entry of client data;
- Process for maintenance of client or service records; and
- Procedures for ongoing communication between collaborators along with a schedule of client case conferences.

Program Coordinator:

A Program Coordinator must be funded as part of each Center of Excellence program. The Program Coordinator is responsible for the logistics of service coordination such as organizing case conferences, ensuring entry of client data into the shared client data/registration system, overseeing the Quality Assurance efforts of the CoE as a whole, and other responsibilities as determined by the specific Center. This position also:

- Serves as lead administrative liaison with the San Francisco Department of Public Health, HIV Health Services (HHS);
- Monitors compliance of parties to the CoE Agreement;
- Identifies and addresses problems and issues affecting the operation of the CoE;
- Facilitates communication among collaborating agencies; and
- Ensures that agreements are kept current and signed between agencies.

The Lead Agency of a CoE collaboration will develop a hiring and evaluation process for the Program Coordinator that includes input from its collaborative partners.

Lead Agency:

Each CoE will have a Lead Agency whose responsibility will include the following activities, some of which may be assigned to the Program Coordinator:

- Development of contractual agreement with the San Francisco Department of Public Health, HIV Health Services (HHS);
- Identifying, hiring, training, and supervising the Program Coordinator;
- Establishing the Center of Excellence Agreement;
- Establishing subcontracts with all providers;
- Continually monitoring the CoE Agreement and subcontracts;
- Ensuring prompt and adequate reporting (including any SFDPH section that is collaborating in the CoE) and invoicing to HHS;
- Ensuring timely and accurate client data entry into the shared client data registration system;
- Ensuring administrative coordination among collaborators, including the facilitation of CoE administrative meetings at least once a month;
- Ensuring logistical and program coordination at the CoE, including assurance that out-stationed staff are utilized and scheduled effectively;
- Organizing trainings for all staff working at the CoE;
- Ensuring quality improvements for the CoE as a whole;
- Conducting an annual provider satisfaction survey;
- Identifying and addressing problems and issues affecting the operation of the CoE; and
- Acting as the primary CoE liaison with HHS.

Policies and Procedures Manual:

In addition to the policies and procedures for individual agencies as part of a multi-site CoE, the CoE shall develop a CoE-wide shared policies and procedures manual that includes general items listed above as well as the following:

- Overview of the integrated services model. including orientation information and service delivery schedule;
- Role and responsibilities of the Program Coordinator;
- Procedures for conflict resolution;
- Policies and procedures for applicable service delivery standards contained in this document and the CoE agreement;
- Procedures for referrals between different CoEs and referrals among providers and programs within one CoE; and
- Procedures for referrals to other agencies and programs in the community.

Required Comprehensive Services:

Centers of Excellence bring together a range of services around primary health care, with the goal of stabilizing clients and assisting them to access and remain in care. Services should follow established Standards of Care for Ryan White services to ensure the highest quality services. To ensure that services provided by a CoE are

accessible to clients and delivered to clients in the vicinity of their primary care, providers of support services shall:

- To the extent possible, have a visible presence at the site where primary medical care is provided to clients; and
- Have regularly scheduled office hours at the location where primary care is delivered as part of the CoE.

Coordination and Integration:

Ensuring seamless coordinated care for clients requires that providers:

- Build a multidisciplinary team made up of representatives that provide core CoE services;
- Work closely with all members of the team to more effectively communicate and address client service related needs, challenges and barriers;
- Conduct multidisciplinary team case conferences every two weeks for shared clients that involve other service providers and participation of the client as appropriate and necessary;
- Ensure the development of a common treatment plan for each individual client;
- Ensure that all staff involved with a given client participate in the development of the individualized care plan;
- Promote attendance CoE staff at key updating, skills building, and service planning meetings within the San Francisco EMA, including quarterly HIV Quality Improvement meetings;
- Ensure that services for clients are provided in cooperation and in collaboration with other agency services and other community service providers to avoid duplication of effort and to encourage client access to integrated health care;
- Ensure an appropriate process for client documentation and chart maintenance that is accessible to all providers within the CoE collaboration; and
- Develop a mechanism for tracking referrals and ensuring clients successfully follow-up on referrals.

Coordination Outside of the CoE for Essential Services:

Ensuring clients have access to the recommended essential services requires providers to:

- Develop and maintain linkages with providers from other agencies to ensure that clients have access to needed services not provided within the CoE (e.g., money management, benefits counseling, and complementary therapies);

- Identify appropriate contacts at each provider agency; and
- Determine referral process and primary staff contacts to effectively facilitate client linkage to services.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

DENTAL SERVICES

DENTAL SERVICES STANDARDS OF CARE

Overview and Purpose of Dental Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Dental Services Standards of Care is to ensure consistency among the Ryan White-funded dental and oral health services provided as part of the San Francisco EMA's continuum of care for persons living with HIV These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Provide access to routine and emergency dental care for persons living with HIV/AIDS who reside within the San Francisco EMA;
- Deliver dental services consented to by clients and approved for reimbursement as determined by a scope of services;
- Provide immediate referrals for emergency treatment including relief of pain or infection;
- Provide access to dental services, treatment, and prevention by licensed dentists or dental hygienists or by undergraduate dental students and dental residents supervised by licensed dentists;
- Provide appropriate referrals when clients have dental care needs that fall outside of the scope of funded services;
- Appropriately address issues of consent and confidentiality for clients enrolled services; and
- Deliver dental services in a culturally and linguistically appropriate manner and comply with all federal, state, and local laws, regulations, ordinances, and codes.

Description of Dental Services

Dental services are defined as diagnostic, prophylactic, and therapeutic oral health services rendered by dentists, dental hygienists, dental students, and dental residents to address the dental and oral health needs of Ryan White clients. While Ryan White Part A and B funding can support the provision of dental and oral health services, two additional Ryan White Part F programs also focus on funding oral health care for people with HIV:

- **The HIV/AIDS Dental Reimbursement Program (DRP)** reimburses dental schools, hospitals with postdoctoral dental education programs, and community colleges with dental hygiene programs for a portion of uncompensated costs incurred by providing oral health treatment to people with HIV.
- **The Community-Based Dental Partnership Program (CBDPP)** supports increased access to oral health care services for people with HIV while

providing education and clinical training for dental care providers, especially those practicing in community- based settings.

Standards for the above two categories of service are separate and distinct from the Dental Services standards of care described in this document.

Units of Service:

A Dental Unit of Service is defined as:

- A face-to-face encounter between a patient and a dentist, supervised dental student, dental resident, or dental hygienist occurring during a single visit; or
- A fee-for-service dental care dollar associated with a pre-determined Unit of Service schedule of eligible dental services.

Dental Services Requirements:

All dental programs and providers must provide the key activities listed below:

Staff Licenses, Credentials, and Experience:

Dental care provider agencies must ensure that all professionals providing Ryan White dental services are properly trained and licensed consistent with state law; have an understanding of the scope of their job responsibilities; and that all programs funded are adequately staffed. Participating dental staff will possess appropriate licenses and expertise to provide dental services; dental students and dental residents must be continually supervised by appropriately licensed dentists.

Oral Examinations and Treatment Planning:

Dental providers should conduct an oral examination and prepare a treatment plan which guides the provider in delivering high quality care corresponding to the client's level of need, including determining the need for emergency versus non-emergency care, triage care, and referral as indicated. The client will review and agree to the treatment plan. If clients access dental services for episodic care only, documentation in treatment notes will reflect clients being advised to return for examination and treatment planning appointments. If the client is not present for this appointment, documentation in the client's chart may serve as a treatment plan.

Service Delivery:

Covered services provided through Ryan White dental and oral health care funding may include:

Emergency Services:

Services for the treatment of pain or infection, including, but not limited to: emergency examinations, diagnostic dental radiographs, caries control, endodontic access, extractions and subgingival curettage. Emergency coverage must be available to clients after hours and on holidays.

Diagnostic Services:

Examinations, diagnostic radiographs and study models. Suggested guidelines are as follows:

- Full mouth radiographs/ Panorex every 3 years or as needed. Patients with rapidly advancing dental decay or periodontal disease may need a complete set of dental radiographs more frequently. The frequency of this service is to be determined by the dental healthcare provider. Patients in need of oral surgery who require a Panorex even though they have had a complete set of diagnostic radiographs within the 3-year timeframe will have this service covered.
- Bitewing radiographs (4 films) every 6 months or as needed.

Preventative Services:

Dental prophylaxis (teeth cleaning), home care instructions and occlusal sealants are covered services. Dental prophylaxis is a covered expense every 6 months.

Restorative Services (Fillings):

Composite resins (tooth-colored) fillings for posterior teeth (premolars and molars), and anterior fillings. Inlays and onlays are not covered services.

Fixed Prosthetics (Crowns and Bridges):

Single unit crowns are covered procedures under the following criterion: teeth having root canal treatment; posterior teeth being used for partial denture abutments (supports); teeth that are badly deteriorated and cannot receive an adequate filling substitute. The following criteria, adopted from Denti-Cal standards, should serve as guidelines for dental healthcare professionals when treatment planning single unit crowns:

✓ **Anterior Single Unit Crowns:**

- Teeth are no more involved that periodontal case type III Good 5 year prognosis
- The involvement of 4 or more surfaces, including at least one incisal angle. The facial or lingual surface shall not be considered as involved for a mesial or distal proximal restoration unless the proximal restoration wraps around the tooth to at least the midline
- The loss of an incisal angle involving a minimum area of ½ the incisal

width and ½ the height of the anatomical crown.

- An incisal angle may not be involved, but more than 50 percent of the clinical crown appears to be involved.

✓ **Posterior Single Unit Crowns:**

- Teeth are no more involved that periodontal case type III
- Good 5 year prognosis
- Posterior teeth used as partial denture abutments
- Premolars (bicuspids): involvement of one cusp and 3 surfaces
- Molars: involvement of 2 cusps and 4 surfaces
- Limitations:
- Crowns will not be covered for cosmetic purposes
- One crown per tooth shall be allowed per 5 year period, unless justified by extenuating circumstances, i.e., onset of severe xerostomia (dry mouth) leading to recurrent decay.

✓ **Fixed Prosthetics (Bridgework):**

- Maxillary anterior single unit fixed bridges will be covered from first premolar (tooth number 5) to first premolar (tooth number 12) as long as no other teeth are missing in the maxillary arch.
- This benefit is to replace one single missing tooth in the anterior portion of the maxillary arch inclusive of teeth number 5 and 12.
- Removable prosthetics shall be offered if more than one tooth is missing in the maxillary arch.

Removable Prosthetics (Removable Partial or Complete Dentures):

To qualify for a partial denture, a patient must have a minimum of three missing posterior (back) teeth within an arch (not counting 3rd molars), or five (or greater) total missing teeth per arch. Patients with missing anterior (front) teeth qualify for removable partial dentures. Repairs to dentures and partials are covered expenses. Complete or partial dentures may be replaced if they cannot be made to fit after relines are completed.

✓ Complete or partial dentures may be replaced after 2 years if any of these criteria apply:

- Prevention of a significant disability
- Catastrophic loss of prosthetic appliance
- Surgical or traumatic loss of oral-facial anatomic structures
- Complete deterioration of the denture base or teeth
- Complete loss of retentive ability

Periodontal (Gum) Treatment:

All necessary scaling and root planing are covered expenses. Periodic periodontal recall is also an approved procedure. Gingivectomy and crown lengthening are covered expenses. Implants are a covered expense wherever possible. Periodontal surgery of all other types are not covered, including osseous surgery, mucogingival surgery, bone grafts, and tissue grafts.

Endodontics (Root Canal Therapy):

Root canal therapy is a covered expense, including posts and tooth build- ups.

Oral Surgery:

Simple extractions, surgical extractions, incision and drainage, and other minor surgical procedures are covered expenses. Surgical removal of complete or partially impacted wisdom teeth is covered. Alveoloplasty to prepare an arch for removable prosthetic is covered. Nitrous oxide and IV sedation are covered upon the approval of the attending dentist.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

EMERGENCY FINANCIAL ASSISTANCE

EMERGENCY FINANCIAL ASSISTANCE SERVICES STANDARDS OF CARE

Overview and Purpose of Emergency Financial Assistance Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Emergency Financial Assistance Standards of Care is to ensure consistency among the Ryan White-funded Emergency Financial Assistance services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. The goal of Emergency Financial Assistance services is to prevent negative client outcomes for persons living with HIV resulting from emergency financial difficulties and to assist clients in securing a financially stable living situation.

Description of Emergency Financial Assistance Services

Emergency Financial Assistance provides limited one-time or short-term payments assist a Ryan White-eligible client with an emergent need to pay for essential items such as:

- Utilities;
- Emergency rent or lodging payments or essential move-in expenses;
- Client transportation
- Essential prescription eyewear;
- Unfunded dental procedures and equipment;
- Unfunded medical equipment;
- Cell phones and data plans; and
- Medications not funded through ADAP.

Additional items or services may also be allowable under this category based on urgent client need and on the unavailability of additional funds to support those needs. Approval for these services must be received from the contracting agency prior to disbursement of funds.

Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Emergency Financial Assistance payments are restricted to one-time or short-term payments to assist a Ryan White client with an emergent need for paying for essential services or equipment for a limited time.

Units of Service:

An Emergency Financial Assistance Services Unit of Service is defined as:

- A single transaction on behalf of a client by an Emergency Financial Assistance provider.

Emergency Financial Assistance Services Requirements:

To receive Emergency Financial Assistance services, clients must submit proof of need for a given payment, such as a utility shut-off notice or a note from a medical or dental provider affirming client need and the lack of any other existing funding to meet that need. Emergency Financial Assistance funds can only be used as a last resort for payment of services and items over a short period of time, and never as ongoing or annual payments. Examples of client emergencies include:

- Facing an imminent threat of losing basic utilities or housing;
- Requiring materials essential to preserving health and well-being such as transportation, eyewear, cellphones, walkers, or other equipment;
- Requiring support for emergency unfunded dental procedures; and
- Helping clients through a temporary, unplanned crisis in order to sustain a safe and healthy living environment.

When accessing Emergency Financial Assistance funds, clients must work with case managers or other service providers to develop a plan to avoid similar emergencies in the future. Changes should be made to the client's care plan to accommodate these plans, where relevant.

Providers must have systems in place to account for disbursed Emergency Financial Assistances funds. The systems must track the client's name, the staff person who distributed the funds, the date of the disbursement, confirmation of receipt of funds, and dollar amounts. These data elements can be tracked on the ARIES Services screen if no other tracking system is available. Emergency Financial Assistance providers must inform clinicians and other key providers when support has been provided, and must provide referrals to clients in need of emergency services not covered through this category such as food and home-delivered meals.

Emergency Financial Assistance providers are required to check in with clients who have received eviction prevention support approximately 90-120 days after receipt of funds to determine if the funds have been effective in preventing eviction.

Emergency Financial Assistance may not be used for:

- Ongoing or annual payments for any services or goods for clients;
- Direct cash payments to clients; and/or
- Activities that can be paid for under another Ryan White service category .

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

FOOD BANK / HOME DELIVERED MEALS

FOOD BANK & HOME DELIVERED MEALS STANDARDS OF CARE

Overview and Purpose of Food Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Food Bank / Home Delivered Meals Standards of Care is to ensure consistency, service equity, and a high degree of quality among food services provided as part of our region's Ryan White HIV continuum of care for persons living with HIV living on low incomes. These minimally acceptable food service standards are designed to provide guidance to food service programs so that they are best equipped to:

- Assess and respond appropriately to the physical, nutritional, dietary, and therapeutic needs of clients;
- Assist clients facing food shortages in securing appropriate food and nutrition services;
- Meet the specific and unique nutritional needs of HIV-positive clients;
- Provide appropriate and effective referrals for nutrition and food-related assessment, care and services as requested or as appropriate;
- Provide food services in as culturally and linguistically appropriate a manner as possible;
- Prepare meals in adherence to Food and Drug Administration standards and requirements; and
- Demonstrate compliance with State sanitation standards and requirements for food storage, preparation, and provision.

In persons living with HIV, good nutrition supports overall health, helps maintain the immune system, and supports the ongoing effectiveness of antiretroviral treatments. Good nutrition also helps people with HIV maintain a healthy weight and better absorb HIV medicines. Because HIV can damage the immune system, foodborne illnesses are likely to be more serious and last longer in people with HIV than in people with a healthy immune system. The purpose of food safety is to ensure that providers understand and effectively follow food safety guidelines in regard to the selection, handling, preparation, storage, and delivery of food in order to reduce or eliminate the risk of foodborne illnesses.

Description of Food Services:

Food and nutrition services promote better health for low-income persons living with HIV through the provision of calorically and nutritionally appropriate foods and

through access to a coordinated network of food and nutrition-related supportive services. Provision of food services may include:

- **Congregate Meals:** The provision of hot, nutritious meals to an assembly of persons in a single location.

- **Food Pantry/Groceries**: Boxes or bags filled with food substances. In some instances, depending on the agency or organization distributing the food bag/box, essential household items may also be included , such as hygiene items and/or household cleaning supplies.

- **Home-Delivered Meals:** Prepared meals delivered to a client at their home or dwelling.

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

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

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

- Household appliances;
- Pet food;
- Alcohol, tobacco, or cannabis products;
- Clothing; and
- Cash payments to clients.

Units of Service:

A Congregate Meal Unit of Service is defined as:

- One prepared meal that meets at least 1/3 of daily nutritional requirements for persons living with HIV

A Food Pantry / Grocery Unit of Service is defined as:

- A selection of groceries meeting at least 1/3 of weekly nutritional requirements for persons living with HIV

A Home Delivered Meals Unit of Service is defined as:

- One prepared meal that meets at least 1/3 of daily nutritional requirements for persons living with HIV

Food Service Requirements:

- All programs shall comply with all applicable State and Local health, sanitation, and safety regulations.
- Prepared meals shall meet the standards set by the National Food is Medicine Coalition (https://fimcoalition.org/wp-content/uploads/2024/03/FIMC_Accreditation-One-Pager.pdf)
- For prepared meals and groceries, plant-based alternatives to animal protein shall be provided. Additionally, foods with science backed, immune system-boosting properties should be provided wherever possible and “ultra-processed” foods shall not be provided.
- All programs shall meet all requirements of the Local health department for food preparation.
- All meal preparation programs shall have obtained a kitchen license from the San Francisco Department of Public Health.

Nutritional Requirements:

- Planning for meals and grocery bags/food boxes can benefit from the use of guidelines developed specifically for persons with HIV, such as Eating Tips: A Nutrition Guide for People Living with HIV, developed by God’s Love We Deliver (www.glwd.org/nutrition/publications.jsp)
- Whenever possible, the special dietary needs and practices of clients shall be considered in menu planning and food preparation, including dietary restrictions and religious and cultural dietary practices.

Program and Staffing Requirements:

- Any agency providing Food Bank/Home-Delivered Meals must comply with federal, state, and local regulations, including any required licensure or certification for the provision of food bank services and/or home-delivered meals. Where applicable, this also includes adherence to any necessary food handling standards or inspection requirements.
- All Food Bank/Home Delivered Meals staff must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include: a) safe food handling procedures; b) confidentiality, and c) knowledge of key points of entry for other Ryan White services.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

HOME AND COMMUNITY-BASED HEALTH SERVICES

HOME AND COMMUNITY-BASED HEALTH SERVICES STANDARDS OF CARE

Overview and Purpose of Home and Community-Based Health Services Standards:

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Home and Community-Based Health Services Standards of Care is to ensure consistency, service equity, and a high degree of quality among home and community-based services provided as part of our region's Ryan White continuum of care for low-income persons living with HIV. Home and Community-Based Health Services are provided to a client with HIV in a residential setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services funded under Home and Community-Based Health Services include:

- Appropriate mental health, developmental, and rehabilitation services;
- Day treatment or other partial hospitalization services;
- Purchase of prescribed durable medical equipment; and/or
- Home health aide services and personal care services in the home.

The objective of Home and Community-Based Health Services is to provide needed services in a home, apartment, group home, or other location in which a low-income person with HIV is residing in order to reduce the risk of hospitalization, prevent entry into a skilled nursing or other long-term care facility, and improve the health, wellness, and quality of life of functionally impaired individuals with HIV.

Description of Home and Community-Based Health Services:

Home and Community-Based Health Services are provided to a client living with HIV in a residential or transitional assisted living setting appropriate to a client's needs, including Residential Care Facilities for the Chronically Ill (RCFCIs) and Transitional Residential Care Facilities (TRCFs), based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Inpatient hospitals, nursing homes, and other permanent long-term care facilities are not considered a residential setting for the purposes of providing home and community-based health services. Services must be provided where the client resides such as own home, apartment or group home. Key activities of Home and Community-Based Health Services include:

- Eligibility screening and intake;
- Comprehensive assessment and regular reassessment of each client's service needs;
- Development and ongoing revision of a comprehensive, individualized service plan;
- Service plan implementation, which may include:
  - Benefits and entitlements counseling and referral;
  - Support services;
  - Durable medical equipment;
  - Skilled nursing services by a Licensed Vocational Nurse (LVN) or Registered Nurse (RN);
  - Home Health Aide and personal care services;
  - Day treatment, one day stay, and partial hospitalization services;
  - Intravenous and aerosolized drug therapy;
  - Diagnostic testing; and/or
  - Mental health, developmental, and rehabilitation services;
- Re-evaluation of the service plan with the client at least every 6 months with revisions and
- adjustments as necessary; and
- Development of follow-up and discharge plans.

Units of Service:

A Home and Community-Based Health Services Unit of Service is defined as:

- One patient day, equal to 8 hours of care

  OR

- One 15-minute contact between a client and a professional or paraprofessional service provider, or a single item of durable medical equipment.

Home and Community-Based Health Care Service Requirements:

Home and Community-Based Health Services must be offered in a manner that addresses barriers to needed care and uses resources and that supports clients remaining in their own homes as long as possible. All Home and Community-Based Health Services must include the key activities listed below:

Orientation:

Each new client enrolled in Home and Community-Based Health Services must receive an orientation to the services at the first visit; this orientation must be documented in the client file.

Intake and Needs Assessment:

The Home and Community-Based Health Services provider must conduct a comprehensive face-to-face intake and needs assessment with each client within 30 days of referral. The intake /needs assessment may be conducted by a nurse, social worker, or other professional Home and Community-Based Health Services staff member, and will describe the client's current status and inform the treatment plan. The intake process, at minimum, involves:

- Reviewing client rights and program services with resident; and
- Obtaining resident consent for treatment, including a signed release for sharing information with other providers to ensure coordination of services.

The comprehensive needs assessment must be conducted by an assigned Nurse Case Manager or Social Work Case Manager and must include at least the following components:

- Overall functional status;
- Current medical care, treatment plan, and providers;
- Assessment of overall client health, including adherence to therapies, disease progression, symptom management, and prevention issues;
- Client's ability to perform activities of daily living and level of assistance required;
- Income, benefits, and health insurance;
- Mental health and psychosocial care and providers;
- Family / social support system and availability;
- Living situation / environment;
- Mental health screening, including outlook and stressors;
- Substance use assessment / screening; and
- Other factors affect the ability of the client to access needed health and social services.

Comprehensive Service Plan and Service Plan Revision:

A comprehensive service plan must be developed in coordination with the client's medical and psychosocial services team within 30 calendar days of the client's referral and re-evaluated at least every six months thereafter with adaptations as needed. Home and Community-Based Health Services providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input;
- Identifies and prioritizes the client's specific home health care needs;
- Incorporates the client's overall Care Plan, if available;
- Addresses the client's medical, social, mental health, environmental, and cultural needs, including referral and linkage to other relevant providers such as case managers, mental health providers, physicians, and housing specialists;
- Involves the input of existing family members and caregivers;
- Specifies the types of services needed, and the quantity and duration of services to be provided, including the need for any durable medical equipment that is determined to be of therapeutic benefit to the client and prescribed by a medical provider; and
- Is signed and dated by the provider.

Throughout the care process, Home and Community-Based Health Care providers and staff will:

- Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation;
- Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services);
- Continually monitor changes in client's physical and mental health and incorporate those changes into revised versions of the care plan;
- Offer nursing care, including medication administration, under the supervision and orders of the client's primary care provider, while administering medications as required or indicated;
- Notify the resident's primary care provider if the resident refuses to comply with prescribed medication regimens;
- Work closely with members of the care team to effectively address client needs;
- Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate;
- Give clients accurate information on available resources to address current and emerging health and psychosocial needs;
- Consult with case managers and care coordinators to facilitate appropriate referrals to programs and services that can successfully meet client needs;
- Assist clients in making informed decisions on choices of available service providers and resources; and
- Address each client's spectrum of needs in a comprehensive way while minimizing duplication of services.

Discharge Plan:

Information gathered during the assessment process should be utilized by a trained and qualified benefits counselor or client advocate to make the following determinations and perform the following functions:

- Home-based providers no longer meet the level of care required by the client;
- Client wishes to discontinue services (with or against medical advice); or
- Client transfers services to another service program or a licensed care facility.

Agencies can consider using the IDEAL model of home-based care discharge planning, which includes the following elements:[1]

- **Include** the patient and caregivers, if present, as full partners in the discharge planning process;
- **Discuss** with the patient and caregivers key areas to prevent problems at home;
- **Educate** the patient and caregivers in plain language about the patient's condition, the discharge process, and next steps at every point in the discharge planning discussion;
- **Assess** how well clinicians have explained client diagnosis, conditions, and next steps in the patient's care to the patient and caregivers by having patients repeat key information and providing additional education as needed; and
- **Listen** to and honor the patient and caregiver's goals, preferences, observations and concerns.

Providers shall notify all relevant client medical and psychosocial providers regarding changes in home health status, and ensure that the decision to terminate Home and Community-Based Care Services is made in termination with the client's primary medical care team.

Program and Staffing Requirements:

Professional diagnostic, therapeutic, rehabilitation, and other treatment services under this service category must be provided by trained and certified practitioners and professionals such as:

- Registered Nurses (RNs);
- Licensed Vocational Nurses (LVNs);
- Marriage and Family Therapists (MFTs);
- Licensed Clinical Social Workers (LCSWs);
- Physical Therapists (PTs);
- Occupational Therapists (OTs);
- Social Workers; and
- Medical Case Managers.

Through these providers, clients may receive day treatment of other partial hospitalization services where appropriate, as well as home-based intravenous and

[1] https://www.axxess.com/blog/home-care/ideal-discharge-planning-in-home-health/

aerosolized drug therapy and prescription drugs administered as part of such therapy. Professional staff may also perform routine diagnostic testing while mental health, developmental, and rehabilitation services may be provided by qualified and licensed staff.

Paraprofessional staff may provide services appropriate for their level of training/education, as part of a care team under the supervision of a licensed or certified clinician. These include but are not limited to:

- Home Health Aides;
- Attendants; and/or
- Homemakers.

Paraprofessional staff should be experienced in providing the services required and have all certifications required by State regulations (e.g., Home Health Aide Certification issued by the State of California). Home Health Aides, Attendants, and Homemakers may monitor vital signs, support activities of daily living, and provide services such as meal preparation, grocery shopping, house cleaning, running errands, and accompanying clients to scheduled medical or related appointments. Attendant care services can also include assisting clients with activities of daily living such as bathing and personal hygiene care and prescribed exercises.

Paraprofessional staff will promptly report to the Supervising RN any problems or questions regarding the client's adherence to medication and report any changes in the client's condition and needs, while completing appropriate client records as required by the Supervising RN.

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

- General HIV knowledge such as transmission, care, and prevention;
- Privacy requirements and HIPAA regulations;
- Communicating effectively and sensitively with clients and caregivers;
- Ensuring communication with the client's medical and psychosocial service team; and
- Awareness and navigation of the local system of HIV care.

Ongoing individual supervision and guidance must be routinely provided to all staff.

San Francisco
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2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

HOSPICE

HOSPICE STANDARDS OF CARE

Overview and Purpose of Hospice Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Hospice Standards of Care is to ensure consistency among the Ryan White-funded hospice services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. The goal of hospice services for people living with HIV is to promote the highest possible quality of life and function for all clients and their families while helping terminally ill clients approach death with comfort and dignity. Hospice services provide a comfort care approach for patients to approach death with dignity and in relative comfort in a supportive atmosphere surrounded by family and/or significant others.

Description of Hospice Services

Hospice services provide 24-hour, culturally competent end-of-life medical care, supervision and assistance for people living with HIV who have been certified by a licensed physician as being terminally ill with a life expectancy of 6 months or less. Hospice care is provided to terminally ill individuals who have voluntarily chosen to receive such care in lieu of curative treatment. Hospice services are focused on ensuring the comfort of patients who are nearing end of their lives, including nursing services; medical social services; medical supplies and equipment; drugs and biologicals; physician services; counseling; dietary counseling; and spiritual counseling. Ryan White-funded hospice services may be provided in a home or other residential setting. This service category does not extend to care offered in skilled nursing facilities or nursing homes.

Allowable hospice services include:

- Nursing services;
- Medical social services;
- Medical supplies and equipment;
- Drugs and biologicals;
- Physician services;
- Mental health counseling, including bereavement counseling, for both clients and family;
- Dietary counseling;
- Laundry and personal living assistance;
- Pharmacy services; and
- Spiritual counseling.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy of six months or less. The decision to

enter hospice care is usually made in collaboration with medical professionals, support personnel, and family members and loved ones, but ultimately must be the decision of the patient themselves. Care and support are offered to each client so that they may live as fully and comfortably as possible within the context of their personal values and symptoms. Services support the client's choices and will be consistent with advance directives, values, spiritual preferences, and life-long patterns of living, even though these decisions may involve increased risk or personal harm to the client.

Units of Service:

A Hospice Unit of Service is defined as:

- A single 24-hour day of hospice services.

Hospice Requirements:

Intake and Assessment:

To receive hospice services, clients must have received a written certification from their physician stating that they are terminally ill and have a defined life expectancy of six months or less. No client will be admitted, accepted for care or discharged without the order of a physician. All persons admitted for care will remain under the continuing supervision of a physician who evaluates them as needed or at least every 30 days. All physician visits will be documented in the patient health record.

The identified hospice provider must conduct a comprehensive initial assessment for services. The assessment will describe the client's current status and inform the needs and services plan. The assessment shall include an assessment of a broad range of client conditions and life factors, including:

- Age;
- Health status and comorbidities;
- HIV prevention needs;
- Psychological needs;
- Spiritual needs;
- Need for pain management and comfort care;
- Current medications and prescriptions;
- Ambulatory status;
- Cognitive abilities and status based on a cognitive assessment;
- Family and support system composition and status;
- Special housing needs;
- Level of independence; and
- Available resources.

Treatment Plan:

An individualized needs and services plan must be developed within 24 hours following the initial client intake, and must be re-evaluated at least every six months thereafter, or as needed. During the treatment plan development process, clients must be provided with education and support regarding issues such as hospice policies and procedures; confidentiality and safety issues; preparation of advanced care directives; and client rights. Written certification from the client's physician stating that the client is terminally ill and has a defined life expectancy of six months or less must be signed again at six months.

The hospice provider must ensure that the individualized treatment plan includes the following elements and consideration, at minimum:

- Incorporates ongoing client input, including a client's right to refuse any aspects of hospice service;
- Only includes allowable activities;
- Includes a statement of the problems or symptoms facing the client;
- Details expected duration of services;
- Ensures coordination of care through collaboration with the client's service providers, such as medical providers, case managers, mental health providers, spiritual advisors, etc.

Service Delivery:

Hospice services should be provided utilizing methodologies most appropriate for the client's needs, and that are responsive to and respectful of the ethnic and cultural identity of clients, including linguistic preference, sexual identity, gender expression and identity, spiritual identification, and other factors. Services provided in as part of hospice care may include the following:

Health Services:

Hospice care supports the provision of comfort medical and health services such as nursing care; medical social services; medical supplies and equipment; comfort therapeutics for symptom and pain control; physician services; and dietary counseling.

Support with Daily Living:

Hospice care includes services to ensure client comfort and support tasks of daily living, such as attendant care services; laundry services; spiritual counseling; and linkage to needed supportive services.

Counseling Services:

Hospice care includes counseling services that are consistent with the definition of mental health counseling, including treatment and counseling by

psychiatrists, psychologists, or licensed clinical social workers.

Supportive Services:

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

Referral / Linkage:

Programs should provide referral and linkage to the full spectrum of HIV-related services.

San Francisco
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Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

HOUSING SERVICES

HOUSING SERVICES STANDARDS OF CARE

Overview and Purpose of Housing Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Housing Standards of Care is to ensure consistency among the Ryan White- funded housing services provided as part of the San Francisco EMA's continuum of care for persons living with HIV These minimally acceptable standards for housing service delivery provide guidance to programs so that they are best equipped to:

- Assist HIV-positive clients and their families and/or partners to deal with access to housing and related services;
- Meet the specific and unique needs of HIV-positive clients;
- Minimize barriers to services;
- Appropriately address client rights and responsibilities for clients receiving housing and related services;
- Provide appropriate and effective referrals for assessment, care, and services;
- Provide housing and related services in as culturally and linguistically appropriate manner as possible, while in compliance with all federal, state and local laws, regulations, ordinances and codes; and
- Assist clients through advocacy and referral in accessing other Continuum of Care services.

Description of Housing Services

The primary goal of Ryan White-funded housing services is to provide transitional, short-term, or emergency housing assistance, including hotel and motel vouchers, that enables a client or family to gain or maintain access to outpatient ambulatory health services and treatment. Housing services also can include housing referral services; housing assessment, search, placement, and advocacy services; and payment of fees associated with these services. Providers must have written policies and procedures that indicate the percentages of a client's monthly rent they can pay through this program.

Ryan White-funded housing categories include:

- **Emergency Housing:** Emergency stays intended to assist clients with immediate housing crises.

- **Transitional Housing:** Short-term residential and transitional housing programs designed to stabilize an individual and to support transition to a long-term

sustainable housing situation. All programs include on–site supportive services.

- **Residential Programs and Subsidies:** Residential housing programs and rental assistance/subsidies designed for longer-term stabilization and are often linked to case management and other services to help stabilize and maintain clients' health.

Ryan-White funded housing services are intended to be temporary in nature. Hotel/motel vouchers and other emergency housing support is available for a maximum of 60 days per year. Meanwhile, the U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24 months if necessary based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline.

Additional allowable activities in this service category include:

- Housing that provides Ryan White core HIV medical or support services, including:
  - Residential substance use disorder services;
  - Residential mental health services;
  - Residential foster care; and
  - Assisted living residential services.
- Housing that does not provide direct core medical or support services, but is essential for a client or family to initiate or maintain access to and compliance with HIV-related outpatient ambulatory health services and treatment. This includes paying or supplementing rent and hotel and motel vouchers when provided on a limited basis as part of an overall plan to transition the client to permanent housing.
- Payment of security deposits to secure permanent housing, with the caveat that security deposits must not be redeemed as cash if a client leaves housing.
- Housing referral services to other (non-HCP) housing programs.

Housing services may not:

- Be used for mortgage payments;
- Be used to make utility payments (these payments are funded under the Emergency Financial Assistance category); or
- Be in the form of direct cash payments to clients.

Ryan-White funded housing services are intended to be temporary in nature. Hotel/motel vouchers are available for a maximum of 60 days per year. Meanwhile, the U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24 months if necessary based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline.

Units of Service:

A Housing Unit of Service is defined as:

- One 24-hour emergency, short-term, transitional housing, or rental subsidy day.

- Additionally, the work of a housing case manager or other provider working to secure or refer clients to housing is defined as one hour of face-to-face individual or group contact between a client and a case manager or one hour contact on behalf of the client within a housing setting.

Housing Services Requirements:

All Housing Programs and Providers Must Provide the Key Activities and Services Listed Below:

- Housing providers will receive referrals from clients in need of emergency, short-term, and transitional housing from local providers and will verify housing client status and needs.
- Housing providers will ensure the absence of alternative resources to meet client housing needs and ensure that Ryan Whtie funds are the funding source of last resort in order to retain clients in HIV care and treatment and preserve health and wellness.
- Providers will develop a housing plan with each client that includes anticipated duration of housing support and essential steps to secure long-term housing. This plan will be developed in coordination with each client's case manager and/or referring service agency. The housing plan will include a preliminary exit strategy that emphasizes the need for each client to secure long-term housing and housing support as rapidly as possible.
- Residential mental health or facility-based care agencies must develop an individual service plan (ISP) for each client within 90 days of intake and must update this plan every 6 months for as long as the client is using Ryan White subsidies.
- Housing providers will offer referrals to needed ancillary services and will track client access to and utilization of housing resources, including ensuring that housing services are allowing the client to remain in HIV care and treatment.
- Clients will be provided with explicit instructions on the process for requesting an extension for housing or housing related services.
- In cases of denial of the extension request, clients will be informed verbally and in writing of the reasons for denial unless a written explanation is deemed clinically inappropriate

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

LEGAL SERVICES

LEGAL SERVICES STANDARDS OF CARE

Overview and Purpose of Legal Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Legal Services Standards of Care is to ensure consistency among the Ryan White-funded legal services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. The goal of Ryan-White funded legal services is to ensure access to justice for low-income and marginalized persons living with HIV and to ensure access to and continuity of benefits and services that maintain optimal health and a higher quality of life for these individuals.

Description of Legal Services

Ryan White-funded Legal Services are designed to help mitigate the impact of restrictive social and economic conditions for people living with HIV by providing professional, relevant, and culturally appropriate legal information, advice, and services. Legal services include consultation, referral, and representation in multiple areas of civil law, including:

- Public and private benefits;
- Advanced planning;
- Credit and bankruptcy;
- Health and disability insurance;
- Housing and eviction prevention;
- Discrimination and confidentiality;
- Immigration and residency status and issues;
- Employment;
- Gender rights; and
- Permanency planning for dependent children.

Legal services may **not** be used to provide criminal defense for clients or to initial or participate in class action lawsuits.

Units of Service:

A Legal Unit of Service is defined as:

- A 15 minute increment of face-to-face, web-based, or telephone contact between a client and a legal services provider.

Legal Services Requirements:

Intake:

An initial client intake is required for all persons with HIV who request or are referred to legal assistance services and should occur at the first meeting with the potential client. In general, a legal services staff member or volunteer should respond within 3 business days to schedule the initial intake with a potential client. The intake records demographic data that includes personally identifiable information such as name, address, and date of birth. Client records for individuals receiving services must be maintained and client confidentiality shall be strictly enforced complying with all relevant legal practice standards of the State Bar of California. The client intake file should, at minimum, include:

- Client contact information, including name, home address, mailing address, phone number, and e-mail address;
- Eligibility documentation, including verification of HIV diagnosis; verification of income; and verification of residence in the San Francisco EMA;
- Emergency and/or next of kin contact information, including name, home address, phone number, and e-mail addresses;
- Release of Information Form that must be updated annually and that specifies what type of information may be released;
- Client Rights and Responsibilities Form; and
- Client Grievance Procedure Form and Limits of Confidentiality.

Legal Assistance and Representation:

Legal service providers will conduct appropriate action on behalf of clients to meet their legal needs. Such action includes offering relevant legal advice and counseling; advocating and negotiating on the client's behalf; providing legal services referrals to other providers and programs, as well as to pro bono attorneys; and representing clients in court and administrative proceedings where appropriate. HIV legal assistance service providers will fully inform clients about the nature of services offered, including their rights to engage in the generation and review of any legal goals and/or strategies; confidentiality issues, and the client's ability to terminate services at any time. It is the responsibility of the client to inform the legal service representative of any communication with other agencies and adverse parties relevant to a given case. Documentation of legal representation efforts shall be maintained in the client record.

Case Closures:

Legal service providers will develop client-centered case closure criteria and procedures that ensure clients who have identified legal needs have access to addressing these needs. All attempts to contact the client and notifications regarding missed appointments and/or case closure will be documented in the client file, along with the justification for case closure. Cases will be closed in accordance with the State Bar of California's Rules of Professional Conduct.

Cases may be closed when the client:

- Has become ineligible for the service;
- Has had no direct program contact in the past six months;
- Is deceased;
- No longer needs the service;
- Decides to discontinue the service;
- Is improperly utilizing the service; and/or
- Has not complied with the retainer contract.

Outreach and Education:

Legal service providers will promote, educate, and conduct outreach to HIV service providers, other supportive service organizations, and potential clients regarding the availability of legal assistance for people living with HIV. Legal service providers will respond to legal questions from HIV providers and will conducting pro-active legal service outreach and education activities to educate and inform HIV service providers on how to access legal services with a specific focus on underserved communities based on socioeconomic status, gender identity, race, sexual orientation, and/or national origin. All HIV-specific legal outreach and education activities will be recorded and reported by the legal service provider.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

MEDICAL & NON-MEDICAL CASE MANAGEMENT

MEDICAL & NON-MEDICAL SERVICES STANDARDS OF CARE

Overview and Purpose of Case Management Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Medical and Non-Medical Case Management Health Standards of Care is to ensure consistency among the Ryan White- funded case management services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Provide client-centered services that respect the client's rights, values, and preferences;
- Coordinate any and all types of services and assistance to meet the client's identified needs;
- Minimize barriers to needed medical and wraparound support services;
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach;.
- Provide continuity of care for people with HIV within a comprehensive system of services throughout the course of their infection; and
- Appropriately address issues of consent, confidentiality, and other client rights for clients enrolled in services.

Description of Case Management Services

Case management for persons living with HIV is a service that links and coordinates assistance from multiple agencies and caregivers who provide psychosocial, medical, behavioral health, and practical support to low-income and disabled persons living with HIV. The purpose of case management is to assist clients in obtaining the highest level of health, wellness, independence, and quality of life possible consistent with their functional capacity and preferences for care. Both medical and non-medical case management continually assess client needs and barriers to care and provide guidance, assistance, and advocacy to help clients access needed medical, psychosocial, community, legal, financial, and other needed services. Case management services can be delivered through many methods of communication including face-to-face contact, internet-based meetings, phone contact, and any other forms of communication deemed appropriate.

While both medical and non-medical case management assess clients and support access to and engagement in services, medical case management services are designed specifically to coordinate care to improve client health outcomes, with a focus on medical and healthcare service access and treatment adherence support, and are generally delivered in the context of clinical facilities and programs. Non-medical case management services have a more general focus and are designed to provide guidance and assistance in improving access to all needed services without a medical focus.

Case management encompasses the following activities or services as part of a multidisciplinary care team:

- Conducting an initial interview to confirm eligibility and collect basic client data;
- Conducting a comprehensive assessment of the client's existing health and functional status, social and familial support systems, income and insurance status, and housing and employment status, among other factors, while identifying psychosocial, medical, and social and practical support service needs and gaps;
- Developing and coordinating an individualized care plan in collaboration with each client based on the results of the assessment and on input from the multidisciplinary team, including an outline of goals, objectives, and activities to meet the client's needs in the context of the client's preferences for services and support;
- Continually implementing the care plan through ongoing accomplishment of the goals and objectives laid out in the Plan by the client and the case manager, including addressing critical and pressing client needs first;
- Ensuring timely and coordinated access to medically appropriate levels of healthcare and support services;
- Coordinating the services that the client receives from various service providers to ensure that the client receives the most appropriate combination of services possible and while avoiding unnecessary service duplication;
- Continually following-up and monitoring the client's care plan with client's caregivers and family members and with members of the multidisciplinary team as appropriate;
- Being available to respond to questions from clients or address emerging barriers and challenges in accessing or remaining in services;
- Assessing client satisfaction with services received to ensure that both the care plan and services are of high quality and that they continue to meet client needs in the most effective way possible; and
- Advocating for the client's access to needed services and support programs wherever appropriate.

Medical case management may also provide benefits counseling services that assist clients in obtaining access to public and private benefits and insurance programs for which they may be eligible when these services specifically support the goal of improving client health care outcomes.

Units of Service:

A Case Management Unit of Service is defined as:

- 15 minutes of face-to-face, web-based, or telephone contact between a client and a case management provider or 15 minutes of activity that directly supports client health and access to services, such as researching client service options, advocating for expedited entry into essential programs, or securing and confirming initial client appointments.

Case Management Requirements:

All medical and non-medical case management programs and providers must provide the key activities listed below:

Initial Screening and Assessment:

All clients referred to case management services will complete an **initial eligibility screening and comprehensive needs assessment interview** conducted by the case manager, generally but not always in the context of a face-to-face interview. The preliminary screening process is designed to ensure client eligibility and appropriate for case management services and to inform the client about the scope of services available through a case management program. During the preliminary screening, providers should:

- Determine whether the client is in a crisis situation and requires immediate service referral and assistance, and work to connect the client to emergency services;
- Determine whether the client's needs for social and practical support can be well served by the specific case management agency or provider and consider whether the case management program is culturally and otherwise appropriately matched to the client;
- Inform the client of the scope of services offered by the case management program, including the program's benefits and limitations;
- Inform the client of their rights and responsibilities as a participant in the program;
- Obtain the client's informed consent to participate in the case management program;
- Gather appropriate client information, including verification of client's HIV status and county address, and determine program eligibility; and
- In collaboration with the client, mutually agree on a decision to go forward with
- the client's enrollment in the case management program.

Following mutual agreement to enter into a case management relationship, the comprehensive needs assessment process will outline the client's current health and service status and identify existing resources, strengths, and service and support needs in order to develop a relevant treatment plan which allows the client to function and

manage their condition as independently as possible. This assessment must be thoroughly documented, and must be client-centered, with the client having the option to defer or not to discuss any specific issues during the assessment). Assessment topics should include the following:

- Current health care and psychosocial services being received and from what providers, including any case management provided elsewhere;
- Current health status / medical history, including last and next medical appointment and most recent CD4 and VL levels;
- Oral health and vision care needs;
- Current medications, levels of adherence, and barriers to adherence;
- Immediate health concerns;
- Substance use history and patterns;
- Mental health and/or psychiatric history and current behavioral health needs;
- Level of HIV health literacy;
- Awareness of safer sex practices and biomedical prevention interventions;
- Sexual orientation and gender identity;
- Sexual history;
- Treatment adherence history, including assessment of ability to be retained in care;
- Self-management skills and history;
- Prevention and risk reduction issues;
- Family composition and level of support;
- Current living situation;
- Languages spoken;
- History and risk of abuse, neglect, and/or exploitation;
- Social community supports;
- Transportation needs;
- Legal issues;
- Insurance, benefits, and income status;
- Emergency financial assistance needs and history;
- Nutritional status assessment;
- Cultural issues, including ethnic, spiritual, cultural, etc.; and
- Summary of unmet needs.

Individualized Care Plan

An individualized care plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed. Case managers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Is individualized and fully incorporates client input;

- Identifies and prioritizes needs identified through the initial assessment;
- Identifies resources to meet the needs identified in the initial assessment and provides referrals to other relevant medical, behavioral health, psychosocial, and support services;
- Includes specific and measurable goals, objectives, activities, with a reasonable timeframe to meet each objective;
- Incorporates client preferences to ensure culturally appropriate and sensitive services; and
- Encourages the client's active participation in the development and implementation of the care plan with the goal of empowering the client and helping them achieve self-sufficiency.

Care plans developed by medical case managers should be medically-focused, and centered around ensuring the client's ongoing engagement and retention in medical services and HIV treatment. Clients being assessed for non-medical case management services who face particular barriers or issues around accessing medical care or treatment should be referred to medical case management wherever possible.

Monitoring and Reassessment:

Both medical and non-medical case management should be seen as an **ongoing process** rather than a finite or time-limited set of objectives**.** Case managers should continually solicit feedback from clients regarding their satisfaction with services, and individualized care plans should be reviewed and revised at each appointment or as required by contract terms, and generally at least **every 6 months** following the initial assessment process. Care plans should also be revised when clients are facing new challenges or life circumstances, or when they face new unmet needs. Ongoing follow-up and monitoring of client care plans ensure that:

- The resources being provided or accessed are sufficient to meet the client's needs;
- Both the case manager and client are working toward their identified care plan objectives; and
- New or changing needs are continually addressed.

Key elements to be addressed during the care plan reassessment process include the following elements:

- Conduct a comprehensive reassessment of the client's medical, psychosocial, and financial condition and service needs;
- Record any changes that have occurred in the client's physical, mental, and psychosocial status since the last formal assessment was conducted;
- Review with the client the adequacy of client's social support network, including adequacy of caregiver support and ability of caregivers to provide needed psychosocial and practical support in light of any changes in client's condition;
- Assess changes in client's financial status or benefits that may affect the client's ability to meet their expenses;

- Discuss with client any legal and financial arrangements such as durable power of attorney, living will, and guardianship of children/dependents if applicable;
- Determine to what extent the goals of the care plan have been achieved since the previous assessment was conducted, including any barriers or obstacles that were encountered;
- Assess the satisfaction of the client with the level of care and services they have been receiving; and
- Assess whether the client requires an increase or decrease in the intensity of case management services the client receives.

Transfer and Discharge:

Transfer or discharge from case management programs occur when the case management program no longer serves the needs of the client, such as when a client has progressed to a more advanced stage of infection and requires more intensive case management; when a client's health status or life conditions have improved to the extent that they no longer need case management services; or when a client moves out of the area, refuses further participation in the program, or is no longer eligible for the program. It is important to ensure that transfer and discharge are not carried out in an abrupt or disruptive manner, but result from a **planned and progressive process** that takes into account the needs and desires of the client and their caregivers, family, and support network. Before undertaking to transfer or discharge a client from case management services, providers should take the following steps:

- If the case manager assesses that the agency is no longer able to meet the client's needs, consult with the supervisor and other members of the multidisciplinary care team to develop a plan for discharging or transferring the client.
- Discuss with the client and their caregivers the decision to discharge the client from the case management program.
- Inform the client of other agencies that might better meet their needs for treatment and support and make arrangements to refer the client to another agency.
- Document in the client's record for the planned transfer or discharge and document in progress notes discussion with the client about planned transfer or discharge.
- Set a reasonable timeline for discharge or transfer that allows sufficient time for the client or their caregivers to make other arrangements for care or treatment.
- Discuss and document process for reinstatement of services should that become necessary and appropriate in the future.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

MENTAL HEALTH SERVICES

MENTAL HEALTH SERVICES STANDARDS OF CARE

Overview and Purpose of Mental Health Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Mental Health Standards of Care is to ensure consistency among the Ryan White- funded mental health services provided as part of the San Francisco EMA's continuum of care for persons living with HIV These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Assist HIV-positive clients and their families, friends, and/or partners to deal with the psychological and emotional aspects of living with HIV by helping them develop healthy coping strategies for both everyday living and for traumatic, life-threatening situations. Mental health services may involve a variety of cognitive, emotional, spiritual, and practical skills, as well as clinical treatments and interventions, linkages to primary care, and medication adherence support;
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach and as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals;
- Promote integration and access to mental health services that sustain a healthy life;
- Minimize barriers to needed medical and wraparound support services;
- Implement coordinated, client-centered, and effective service delivery;
- Appropriately address issues of consent, confidentiality, and other client rights for clients enrolled in services; and
- Deliver mental health services in a culturally and linguistically appropriate manner, within individual programs or through referral, while in compliance with all federal, state and local laws, regulations, ordinances and codes.

Description of Mental Health Services

Mental health services in the context of Ryan White funding refer to psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional, including psychiatrists, psychologists, social workers, marriage and family therapists, counselors, and peers in an outpatient or residential health service setting or through web-based, telephone, or other remote methods mutually agreed

upon by the mental health provider and the client. Mental health services are designed to assist clients in coping with the emotional and psychological aspects of living with HIV, improve psychological well-being, and increase quality of life through counseling and adherence to medical care. Mental health services include mental health assessment; treatment planning; individual psychotherapy; family psychotherapy; group psychotherapy; psychiatric medication assessment, prescription and monitoring; drop-in psychotherapy groups; and crisis intervention services. All interventions must be based on proven clinical methods and in accordance with legal and ethical standards.

Units of Service:

A Mental Health Unit of Service is defined as:

- 15 minutes of face-to-face, web-based, or telephone contact between a client and a provider or 15 minutes of face-to-face or telephone contact between a client's provider and another provider in support of the client's treatment and wraparound support needs. A psychiatric consultation is defined as face-to-face, web-based, or telephone encounter between a psychiatric professional and an individual client.

Mental Health Requirements:

Staff Licenses, Credentials, and Experience:

Participating staff will possess licenses, credentials, and/or experience appropriate to the services they provide, in accordance with CMHS standards.

- Individual, group, couples, and family therapy and counseling must be provided by a licensed and/or board certified psychiatrist, psychologist, social worker, marriage and family therapist, professional clinical counselor, or psychiatric nurse. License-eligible professionals, life-experienced individuals, individuals with credentials other than a U.S.-based license, clinical trainees, and volunteers may also provide these services only with clinical supervision by a licensed professional. Services provided shall be commensurate with the experience of the staff persons involved.

- Staff members providing Ryan White mental health services will ideally have professional or lived experience of HIV, or a combination thereof, as well as a sense of commitment and ethical concern for those being served and an understanding of unique needs of HIV- positive individuals.

Intake and Assessment:

All clients referred to the program will receive an intake assessment by a mental health professional in accordance with CMHS requirements. In addition, Ryan White programs shall also collect the following on intake, during subsequent assessments,

or as part of ongoing assessment associated with treatment planning, where relevant:

- Assessment of STI/HIV risk and prevention education needs;
- HIV/AIDS-related medical history, including medication adherence and engagement in medical care;
- Assessment of how client's HIV disease and other life circumstances or challenges may affect the client's ability to participate in the program;
- Identification of mental health needs related to the ethnic and cultural identity of clients, including linguistic preference, sexual identity, gender expression and identity, spiritual identification, and other factors;
- Assessment of client's substance use and history;
- Grief/loss inventory; and
- Client strengths.

Treatment Plan:

An individualized treatment plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed. Mental health providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input;
- Identifies and prioritizes the client's mental health care needs;
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment, including barriers to HIV treatment and treatment adherence;
- Sets realistic and measurable goals, objectives, and treatment timelines based on client needs identified by the client and the mental health team, including frequency and expected duration of services;
- Identifies interventions, modalities, and resources to attain the goals and objectives, including arrangements for web-based, telephone, or other remote methods as agreed upon by both the client and the provider team and referral and linkage to other relevant providers such as substance use counselors, physicians, or housing specialists; and
- Includes a substance use treatment/harm reduction plan where appropriate.

The treatment plan should be reviewed and revised at each appointment or as required by contract terms.

Service Delivery:

Services should be provided utilizing methodologies appropriate for the client's needs and following national recommendations for HIV mental health care guidelines. This may include any combination of:

- Individual counseling/psychotherapy;
- Family counseling/psychotherapy;
- Couples counseling/psychotherapy;
- Group psychotherapy/treatment;

- Drop-in groups;
- Crisis intervention services; and
- Psychiatric medication assessment, prescription, and monitoring.

San Francisco
HIV Community
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2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

MONEY MANAGEMENT

MONEY MANAGEMENT STANDARDS OF CARE

Overview and Purpose of Money Management Services Standards:

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Money Management Standards of Care is to ensure consistency, service equity, and a high degree of quality among services provided as part of our region's Ryan White HIV continuum of care for persons living with HIV on low incomes. These minimally acceptable standards are designed to provide guidance to Money Management programs so that they are best equipped to:

- Provide money management services and assist clients in maintaining stable housing by guaranteeing that their rent is paid promptly;
- Provide representative payee services;
- Assist in identifying clients' needs for benefits and make appropriate referrals to benefits counselors;
- Reach out to PLWHA in need of agency services;
- Meet the specific and unique needs of HIV-positive clients;
- Support clients' access to and ongoing follow-up with primary and other supportive services;
- Participate in coordinated, client-centered, and effective service delivery networks;
- Identify and address barriers to services;
- Appropriately address issues of consent, confidentiality, and other client rights, for clients enrolled in services; and
- Address client needs using a multidisciplinary team approach.

Description of Money Management Services:

Money management includes **two** categories of service provision: 1) **Benefits Management**, including budget planning, establishing bank accounts, authorizing and managing disbursements; and 2) **Representative Payee Services**. As a representative payee, the agency receives payments on behalf of clients from a wide variety of agencies and sources, including the Social Security Administration, the Veterans Administration (VA), the COVID-19 Accelerated and Advanced Payment (CAAP) program, client employers, and other sources. Both categories of service provision encompasses the following activities or services as a part of a multidisciplinary care team:

- Prompt payment of client's rent using client funds in order to maintain stable housing;
- Use of client's funds, as applicable, to pay for other current and foreseeable needs of the client such as bills, medication, and transportation;
- Ongoing budget planning conducted in collaboration with the client;
- Disbursement of funds to client according to a disbursement schedule through vehicles such as checks, direct deposits, funds issued on client debit cards, and electronic payments to vendors;
- Fulfilling all duties of a representative payee as required by the Social Security Administration (www.ssa.gov/payee/faqrep.htm);
- Communicating client service-related needs, challenges, and barriers to case managers and/or other service team members;
- Fostering and maintaining relationships with client's landlord or property holder;
- Maintaining working relationship with Social Security Administration and other county agencies and sources of benefits such as the Department of Human Services, Veterans Administration, and Employment Development Department; and
- Conducting outreach to prospective clients and community organizations to inform them of money management services available.

In addition, representative payees must be familiar with the following guidelines:

- Social Security Administration Guide for Organizational Representative Payees (http://www.ssa.gov/payee/NewGuide/foreword1.htm)
- Social Security Administration Guide For Representative Payees, SSA Publication No. 05-10076, August 2001, (http://www.ssa.gov/pubs/10076.html)

Units of Service:

A Money Management Unit of Service is defined as:

- One hour of face-to-face contact between a client and one hour of face-to-face contact between a client and a money manager/client advocate;

  OR

- One hour of contact or work on behalf of the client.

Money Management Requirements:

All Money Management programs and provider must provide the key activities listed below:

Intake and Enrollment:

- Obtain client information including eligibility and demographic information;
- Obtain client consent for services including a signed release for sharing information with other providers to ensure coordination of services;
- Complete forms with appropriate benefits counseling programs designating agency as the client's money manager / representative payee;
- Develop a personal budget in collaboration with and with full agreement by the client, detailing rent, bill payments, and personal expenses, as well as plans for saving, as appropriate;
- Inform client of income disbursement schedule and agency procedures for requesting income disbursement;
- Establish and maintain contact with the client's landlord, when appropriate; and
- Refer clients to benefits advocacy, benefits counseling, and representation services.

Distribution of funds:

- Disbursements of client funds, including rent, bill payments, and client personal expenses, are issued in the form of checks, direct deposits, funds issued on client debit cards, and electronic payments to vendors;
- Individual client files should accurately record all transactions pertaining to client's funds; and
- Client should be informed that a transaction record is available to him/her upon request at any given time.

Information and referral:

- Provide client with accurate information on available resources in the County served by the program;
- Coordinate efforts with appropriate benefits counseling programs, also referred to as benefits advocacy and representation programs;
- Maintain appropriate referral relationships with agencies and providers, both within and outside of the HIV care system, in order to assist client in accessing services such as benefits counseling, shelters, treatment programs, HIV counseling and testing, and mental health programs;
- Consult with client case managers/care coordinators to facilitate appropriate referrals to programs and services that can successfully meet the client's needs; and
- Assist clients in making informed decisions on choices of available service providers and resources.

Outreach:

- Provide and disseminate program information to community organizations such as HIV service organizations, benefits counseling programs, public assistance programs, mental health providers, substance use treatment programs, and SRO hotels to inform them of services offered by the agency.

Coordination with the Multidisciplinary Team:

- Agencies providing Money Management services shall ensure that services for clients are provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encourage client access to integrated health care. Money management professionals will work closely with each client's case managers, benefits counselors and advocates, public assistance programs, treatment advocates, medical providers, and other members of care team to communicate client service related needs, challenges and barriers.

San Francisco
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Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

OUTPATIENT / AMBULATORY HEALTH SERVICES

OUTPATIENT / AMBULATORY HEALTH SERVICES STANDARDS OF CARE

Overview and Purpose of Outpatient / Ambulatory Health Services Standards:

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Outpatient / Ambulatory Health Services Standards of Care is to ensure consistency among the Ryan White- funded outpatient / ambulatory health services provided as part of the San Francisco EMA's continuum of care for persons living with HIV These minimally acceptable standards for service delivery provide guidance to programs so that they are best equipped to:

- Promote integrated health care services that maximize quality of life, address the spectrum of patients' health care needs, and minimize barriers to accessing services;
- Promote collaborative relationships between clinicians and patients and between service providers to maximize patient health;
- Implement coordinated, patient-centered, and effective service delivery;
- Ensure respect for patients;
- Encourage clinicians to remain up-to-date regarding treatment guidelines and to comply with all federal, state and local laws, regulations, ordinances, and codes;.
- Meet the specific and varied needs of HIV-positive clients using a multidisciplinary team approach and as appropriate, conduct HIV risk reduction specifically for HIV-positive individuals;
- Appropriately address issues of consent and confidentiality for patients enrolled in services;
- Deliver primary care services in a culturally and linguistically appropriate manner, that takes into account the nature of patients' family, social, and community beliefs, traditions, preferences, support systems, and networks; and
- Ensure the availability of substance abuse harm reduction and primary and secondary prevention education services.

Ryan White Outpatient / Ambulatory Health Services are intended to support the health and wellness of low-income persons living with HIV through the provision of primary medical care for the treatment of HIV infection consistent with the most recent US

Public Health Service (PHS) guidelines, also known as Health and Human Services (HHS) guidelines.

Description of Outpatient / Ambulatory Health Services

Ryan White-funded Outpatient / Ambulatory Health Services are defined as diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical or remote setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency department or urgent care services are not considered outpatient settings. Outpatient / Ambulatory Health Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

Allowable activities in this service category include:

- Medical and sexual history taking;
- Physical examinations;
- Diagnostic testing, including laboratory testing;
- Treatment and management of physical health conditions, including sexually transmitted infections (STIs);
- Behavioral risk assessment, counseling, and referral;
- Preventive care and screening;
- Prescription and management of medication therapies;
- Treatment adherence counseling and support;
- Nutrition screening and referral;
- Education and counseling on health and prevention issues;
- Referral to and provision of specialty medical care services;
- Information on and linkage to appropriate clinical trials opportunities; and
- Ongoing care and management of chronic conditions.

Units of Service:

An Outpatient / Ambulatory Health Unit of Service is defined as:

- A 15-minute contact between a client and Outpatient / Ambulatory Care staff;
- Provision of a laboratory test;
- Provision of a single item of durable medical equipment; and/or
- Provision or administration of medication.

Additional services directly related to outpatient medical care of patients may also be allowable as Outpatient / Ambulatory Health unit of services as agreed to by medical providers in collaboration with Part A grantee.

Outpatient / Ambulatory Health Services Requirements

All outpatient / ambulatory health programs and providers must provide the key activities listed below:

Staffing Qualifications:

Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Physicians (MD/DO);
- Physician's Assistants (PA); and/or
- Nurse Practitioners (NP).

Other professional and non-professional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Nurses (RN, LVN/LPN);
- Medical Assistants (MA);
- Pharmacists; and/or
- Pharmacy Assistants.

Any non-clinician staff providing services must be: a) supervised by a clinician; b) hold current licensure as required by the State of California wherever applicable; c) provide services appropriate for their level of training and education; and d) be trained and knowledgeable regarding HIV care standards as described below.

Initial Ambulatory / Outpatient Care Appointments:

Initial Outpatient / Ambulatory Health Services appointments should be made as soon as possible to avoid potential drop out. Appointments should occur no later than 10 calendar days after the first client request or referral from another provider, but should be scheduled sooner whenever possible. In order to facilitate rapid initiation of antiretroviral therapy, persons newly diagnosed with HIV should have their first appointment occur within 2 business days of diagnosis. Non-urgent appointments and appointments for existing patients must be scheduled as soon as feasible, but generally no more than 60 days after client request in order to minimize the need for urgent or emergency services, or the interruption of services. As clients may miss appointments, agencies must have a process in place to

ensure timely follow-up, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented.

Intake and Assessment:

All clients referred to Outpatient / Ambulatory Health Services will receive an initial medical assessment by an outpatient / ambulatory health professional in accordance with HHS guidelines. Components of this initial assessment should include:

- ### Medical Evaluation:

  At the start of Outpatient / Ambulatory Health Services, a baseline medical evaluation must be conducted. This evaluation should be performed in accordance with HHS guidelines, HIV primary care guidelines, and California Department of Health Services STD guidelines.

- ### Patient Education:

  Patients should continually be provided with information regarding the results of diagnostic tests, prognosis, risks and benefits of treatment, instructions on treatment management and follow up, and treatment adherence. Patients should be provided with information on effective health maintenance strategies in areas such as nutrition and physical activity, and other services available to them, including harm reduction services and alternative therapies. In addition, patients should be given education on HIV and STI risk reduction and prevention.

- ### Partner Services:

  Per HCP Management Memo 15-06, HCP providers funded for Outpatient / Ambulatory Care Services must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes. Wherever possible, all patients should have access to a provider of their choice and should be given the option to transfer their care to another provider if they are dissatisfied. Providers must also consider the delivery of outpatient / ambulatory care services in relation to the ethnic and cultural identity of clients, including linguistic preference, sexual identity, gender expression and identity, spiritual identification, and other factors. This includes providing alternate methodologies for providing medical consultation - such as web-based consultation appointments - and ensuring the availability of culturally competent translation services.

Treatment Plan:

An individualized patient treatment plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed. The treatment plan must be developed in collaboration with the patient, and the clinician must note the plan in the chart, review the plan regularly with the patient, and update the plan regularly or as needed. The plan must address cognitive, social,

economic, and other barriers to access for patients, including collaboratively identified strategies for address barriers to appointment and medication adherence. Patients must be assisted in determining how to deal with their after- hours medical needs, such as how to determine whether symptoms require emergency care, where to access 24-hour emergency care, and who to call for after-hours medical advice. Patients must also have access to telephone clinical advice 24 hours a day, 7 days a week.

Service Delivery:

In general, patients should have follow-up visits scheduled every three to six months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence to their medical regime. Practitioners will discuss and conduct tests related to general preventive health care and health maintenance with all HIV-infected patients routinely, and at a minimum, annually. Routine medication adherence assessments will be performed for patients, and, if the need is indicated, clinicians will work with patients to develop an individual service plan (ISP) for treatment adherence for patients who face barriers in maintaining adherence. ISPs will be developed in collaboration with the patient and to address identified needs and will be revised at a minimum of every six months.

Ongoing service delivery shall also include:

- Referral to and coordination with medical specialty and subspecialty care as indicated by client conditions;
- Testing and treatment for sexually transmitted infections and linkage to and/or provision of biomedical STI prevention treatment;
- Screening for substance use disorders and access to harm reduction counseling and client education; provision of and/or referral to medication-assisted treatment (MAT) for substance use disorders, including buprenorphine for OUD or reduction of opiate overdose risk and referral to certified methadone maintenance clinics; and access to or referral to access harm-reduction supplies, including naloxone for emergency opiate reversal;
- Referral to nutritional counseling and support services as indicated by nutrition screenings;
- Referral to HIV clinical trials and research programs as deemed appropriate by the provider working in collaboration with the patient; and
- Discussions of the potential benefits and risks of complementary, alternative, and experimental therapies.

All ambulatory / outpatient health services will be patient-centered, respecting the inherent dignity of the patient. Programs must ensure that patients are given the opportunity to ask questions and receive accurate answers regarding services provided by clinical practitioners and other professionals to whom they are referred. Such patient-practitioner discussions are relationship-building and serve to develop trust and confidence. Patients must be seen as active partners in decisions about their personal health care regimen.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

OUTREACH SERVICES

OUTREACH SERVICES STANDARDS OF CARE

Overview and Purpose of Outreach Services Standards

The purpose of the San Francisco Eligible Metropolitan Area (EMA) Outreach Services Standards of Care is to ensure consistency among the Ryan White- funded mental health services provided as part of the San Francisco EMA's continuum of care for persons living with HIV. The purpose of Outreach Services is to identify persons who are unaware of their HIV- positive status or persons who know their HIV-positive status but have fallen out of care so that they may become aware of and enrolled in HIV medical care and treatment services.

Description of Outreach Services:

Outreach services in the context of Ryan White funding include the provision of the following activities:

1. Identifying persons who did not previously know they were living with HIV, and linking those persons to HIV medical care and treatment services;
2. Identifying persons who already know their HIV-positive status but are not in care and linking or re-linking those persons to HIV to HIV medical care and treatment services, including locating agency clients who have been lost to care;
3. Accompanying clients to medical and psychosocial appointments as needed; and
4. Providing information and education on health care coverage and benefits options and social service programs where appropriate.

Outreach Programs Must Be:

- Conducted at times and in places where identified priority populations are likely to be present, with priority populations identified through surveillance, continuum of care, and other available data;
- Planned and delivered in coordination with other HIV prevention, outreach, testing, linkage, and care programs in order to avoid duplication of effort;
- Delivered in a manner that is sensitive and responsive to the ethnic and cultural identity of clients, including linguistic preference, sexual identity, gender expression and identity, spiritual identification, and other factors; and
- Delivered in a manner that is respectful of client concerns, preferences, and prior experiences with the medical and/or social service system.

Outreach Services May Not:

- Be used to pay for HIV counseling or testing;
- Be used for outreach activities that exclusively promote HIV prevention education;
- Be used for broad outreach activities, such as providing leaflets at a metro stop or posters at bus shelters; and
- To supplant funding for outreach activities funded by the Centers for Disease Control and Prevention or other federal, state, or local sources.

Units of Service:

An Outreach Unit of Service is defined as:

- 15 minutes of face-to-face, web-based, or telephone contact between a client and an outreach services provider.

Outreach Services Requirements:

Outreach Services must be offered in a manner that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. Outreach workers should maintain a consistent presence in the target community in order to find newly diagnosed or identified people living with HIV and help link them to necessary services. All outreach services must be culturally and linguistically appropriate for the target population. All programs providing outreach services will develop a protocol to ensure worker and client safety. When appropriate, outreach workers may accompany clients to initial visits to primary care and/ or case management services.

- **Service Coordination:**

  Outreach services must be planned and delivered in coordination with local HIV prevention, outreach, testing, linkage, and care programs to avoid duplication of effort. Outreach services reimbursed through Ryan White CARE Act funding cannot take the place of HIV prevention services offered by other programs.

- **Priority Populations:**

  Outreach Services must be focused on populations and communities known to be at disproportionate risk of HIV infection. Broad-scope awareness activities for the general public, such as transit ads, are not considered focused services, although smaller group-based gatherings and campaigns narrowly focused on reaching a specific underserved or disproportionately impacted population can be considered focused services.

- **Key Locations:**

  Services should be conducted at times and places where there is a high probability that people living with HIV will be reached. Examples includes offering services at specific establishments, venues, and locations frequented by persons likely to have participated in high-risk behavior; outreach conducted on the street or in homeless encampments; and services offered at times outside of normal business hours.

- **HIV Education:**

  Clients should always be provided with HIV risk reduction and prevention education, information about partner services, and referrals to the HIV service delivery system including clear information on how to access those services, as a part of outreach and service linkage efforts.

- **Referral / Linkage:**

  Clients should be referred for testing as appropriate; those testing positive HIV should be referred to and linked to HIV medical care, case management, benefits counseling, and other services necessary to maintain or improve health outcomes as appropriate, using a warm handoff wherever possible. Documentation of that referral must be in the client file and available upon request.

San Francisco
HIV Community
Planning Council

2024 San Francisco EMA Ryan White HIV

STANDARDS OF CARE

PHYCHOSOCIAL SUPPORT

PHYCHOSOCIAL SUPPORT STANDARDS OF CARE

Overview and Purpose of Psychosocial Support Services Standards

The San Francisco HIV Planning Council developed the Psychosocial Support Services Standards of Care to ensure that people living with HIV (PLWH) in San Francisco are receiving culturally competent, trauma-informed and non-judgmental services that help them cope with their diagnosis and any other psychosocial stressors they are experiencing.

The purpose of psychosocial support services is to remove or lessen client barriers to care and treatment, increase client self-efficacy, and ensure access to a broad-based support system through counseling services and mental health support. Psychosocial support services provide group or individual support and counseling services to assist people with HIV to address behavioral and physical health concerns and access a safe space where lived experiences and challenges can be discussed without judgement. Psychosocial support services are client-centered and may include individuals who are newly diagnosed, newly identified as living with HIV, or who require additional support to engage in and maintain HIV medical care and supportive services. The objective of psychosocial services is to not only provide counseling and support services, but to ensure clients are linked to care and continuously supported to remain in care.

Description of Psychosocial Services

Psychosocial support services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. Psychosocial support services are associated with improved engagement in HIV care for the purpose of improving health outcomes. Agencies are expected to prioritize services to individuals who are having difficulty remaining engaged in HIV care.

Key activities of Psychosocial Support Services may include:

- Support and counseling activities;
- HIV support groups ;
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services for services provided by Registered Dietitians);
- Client navigation and education services;
- Child abuse and neglect counseling;
- Pastoral care/counseling services;

- Bereavement counseling; and
- Volunteer support.

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

Funds under this service category may **not** be used to pay for:

- Nutritional supplements (see Food Bank/Home Delivered Meals Standards of Care);
- Social/recreational activities;
- Gym memberships; or
- Psychotherapy services provided by a licensed mental health provider (see Mental Health Services Standards of Care).

A key component of psychosocial support services for PLWH and those affected by HIV is to provide services that are centered on **trauma-informed care.** Psychosocial services also provide a strength-based framework that emphasizes physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.

Units of Service:

A Psychosocial Support Unit of Service is defined as:

- A 15-minute contact between a client and a counselor or other provider of allowed psychosocial support services. When clients attend group-related services, sign-in sheets should be maintained and UOS should be allotted for each client (e.g., if five clients attend a one-hour support group, the service should be recorded for each client as four units at 15 minutes each).

Psychosocial Services Requirements:

Psychosocial services programs and providers must provide the key activities listed below:

Intake and Assessment:

Each new client enrolled in Psychosocial Support Services must receive an orientation to the services at the first visit; document this orientation in the client file. While treatment plans are not required for this service category, an initial review of client needs, personal support systems, and current services is highly recommended, and an individual service plan may be developed for high-acuity clients facing a range of challenges and needs, and that includes referral and linkage to needed related services.

Service Delivery:

The goal of psychosocial support group services is to provide a forum in which lived experiences, challenges, and health concerns of persons living with HIV can be discussed without judgement. In addition, support groups aim to increase participant knowledge and awareness of HIV-related topics; build a trusting network among participants as well as with the facilitator; and empower participants to maintain their highest level of optimal mental, physical, and emotional health. Topics discussed in support groups include, but are not limited to:

- Living with HIV;
- Healthy lifestyles, including substance use and relationships;
- Adherence to treatment;
- Access and barriers to care;
- Prevention, including PrEP, PEP, and treatment as prevention;
- Disclosing status; and
- HIV stigma.

Psychosocial services providers must ensure a safe, confidential space for participants to discuss topics of interest through group facilitation techniques. Meeting locations must be accessible and affordable for participants. To reduce barriers to accessing care, an agency may offer online counseling and therapy services or telepsychology through phone, webcam, email or text message appointments depending on its capacity and/or contract guidelines. Agencies must comply with established agency confidentiality policies when soliciting information from external sources.