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SOUTH CAROLINA RYAN WHITE PART B

PROGRAM SERVICE STANDARDS

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INTRODUCTION

The Ryan White HIV/AIDS Program is the most extensive federal program focused primarily on HIV/AIDS care. The United States Congress enacted the Ryan White program in 1990. The program was reauthorized in 1996,

2000, 2006, and 2009 with each reauthorization accommodating new and emerging needs. South Carolina Department of Health and Environmental Control (DHEC) is the agency in South Carolina responsible for administering the Ryan White Part B grant. The grant is managed by the STD/HIV Division within the Bureau of Disease Control. The overall goal is to improve the quality and accessibility of care and support services to those individuals infected with HIV.

HRSA's National Monitoring Standards (NMS) are used for compliance, oversight, and expectations. The Ryan White Part B Program Service Standards follow the programmatic requirements outlined in the National Monitoring Standards compiled by HRSA. The standards function to ensure that all Ryan White Part B service providers offer the same fundamental components of a given service category across the state and to establish the minimal level of Service or care that a Ryan White funded provider may offer. The Service Standards are consistent with applicable clinical and/or professional guidelines, best practices, state and local regulations, and licensure requirements. The standards outline vital components of each service category and establish performance benchmarks to monitor the degree to which services provided meet or exceed established professional standards and user expectations.

ELIGIBILITY

To be eligible for SC RWB services, each Client must meet the following criteria:

- Confirmed diagnosis of HIV or AIDS prior to receiving Service
- Residence in SC and not a state or federal prison
- Income at or below 550% of the Federal Poverty Level (FPL)
- Third-party payment must be used to ensure RW is the payer of last resort

Refer to SC ADAP Eligibility Guidelines for more detailed information on eligible income limits and eligibility details.

HRSA HAB PCN 21-02 has eliminated the six-month recertification requirement and has given HRSA HAB recipients the ability to determine client eligibility, including complying with payor of last resort requirement, while minimizing the administrative burden and enhancing continuity of care and treatment services of individuals living with HIV/AIDS. SC DHEC has determined, based off the guidance provided by PCN 21-02, that eligibility verification will only be required once, during the enrollment into the RWB and/or ADAP program, and once annually, from that enrollment date or the date of the last eligibility verification.

PCN 21-02 states people are eligible to receive RWHAP services when they meet each of the following factors:

- HIV Status
    - A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds,3 and as otherwise stipulated by HRSA HAB.)
- Low Income
    - The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).
- Residency
    - The RWHAP recipient defines its residency criteria, within its service area.

Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services.6 RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

RWHAP funds may be used to fill in coverage gaps for individuals who are either underinsured or uninsured to maintain access to care and treatment services as allowable and defined by the RWHAP. RWHAP funds may be used for core medical and support services if those services are not covered or are only partially covered by another payer (such as private or employer insurance, Medicaid, or Medicare), even when those services are provided at the same visit.

While SC DHEC has allocated SC RWB funding by service area, clients can be served outside their service area if the SC RWB Agency has funds available. SC RWB service areas include counties (regions) that differ from state health regions.

Medical Case Management and related services cannot be conditioned upon where medical care is provided. Clients may receive RW medical case management services from more than one provider.

Ryan White Part B funded providers must be open to all eligible clients in accordance with federal and state laws. Ryan White Part B providers must see all clients regardless of past or current medical conditions.

Clients with one positive immunoassay may be linked to a Ryan White Part B provider for the purpose of confirmatory testing. Ryan White services should not be provided until the Client has confirmed HIV disease, confirmed through one of the following options:

- Positive HIV immunoassay and positive Western Blot or Multispot,
- Positive HIV immunoassay and detectable HIV RNA, or
- Two positive HIV immunoassays (should be different assays based on different antigens or different principles).

INCARCERATED POPULATIONS

Incarcerated Population (See PCN 18-02) This Policy Clarification Notice (PCN) replaces HRSA HAB policy notice #07-04. The purpose of this PCN is to provide guidance to HRSA RWHAP recipients and subrecipients on the use of program funds to provide HRSA RWHAP core medical services and support services:

1. On a transitional basis to people living with HIV (PLWH) who are incarcerated in Federal and State prison systems
2. On a short-term and/or transitional basis to PLWH who are incarcerated in other correctional systems (e.g., local prisons and jails) or under community supervision (e.g., parole or home detention).

Federal and State Prisons

- Inmates within federal and state prisons are not eligible for Ryan White Part B services other than transitional services within 90 days of release where no other services exist.

County and City Jails

- Ryan White Part B program funds can be used to provide core and supportive services in local jails (i.e., county or city) if these institutions are not legally responsible for and/or financially able to meet the HIV/AIDS care and treatment needs of all persons in their custody.

Probation

- Persons who are on probation or parole are eligible for Ryan White Part B services since they are living in the community and are not in the care or custody of a jail or prison system.

VETERANS

Veterans may not have access to comprehensive medical care even if eligible for VA medical benefits and are thus exempt from the "payer of last resort" requirement and eligible for Ryan White services. Similarly, those eligible for Indian Health Services are exempt from the "payer of last resort" requirement, also deeming them eligible for Ryan White services.

MEDICAID & OTHER HEALTH CARE PROGRAMS

Eligibility for or enrollment in Medicaid or other health care programs may not be the sole factor in determining whether RWB services may also be needed to support the Client care plan (i.e., accessibility limits to Medicaid transportation or non-RW Case Management).

- While DHEC has allocated Part B funding by service areas, clients are eligible to be served outside their service area if the Part B funded organization has funds available, and the Client resides in South Carolina.

ALLOWABLE USES OF PART B SERVICE FUNDS

Part B Funds Only to Support

- Core medical services
- Support services that are needed by individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS-related clinical status (Note: All services provided through consortia are considered to be support services)

RFGA, contract, and statements of work language describe and defines Part B services within the range of activities and uses of funds allowed under the legislation and defined in HRSA Policy Notices.

Subrecipient Requirements

- Provide the services described in the contract that allows the use of Part B funds only for the provision of services and activities allowed under the legislation and defined in referenced Policy Notices
- Invoice only for allowable services
- Maintain in files that only allowable activities are being billed to the Part B grant
- All services provided, core and support, must be documented in client record (*Provide Enterprise*) Providers of Medicaid-reimbursable services must be participating and certified to receive Medicaid payments or able to document efforts underway to obtain such certification
- Providers must bill third parties for all reimbursable services

OTHER PROGRAMMATIC REQUIREMENTS

Documentation

- Documentation for all services provided must be entered into client record (*Provide Enterprise*) accurately and timely.
    - All services provided must be documented in *Provide Enterprise*.
    - Professional disciplines will provide services and complete documentation of care/service provided according to professional standards and guidelines.
    - All core and supportive services provided will be documented in client record (*Provide Enterprise*).

- Providers to have protocol for ensuring accuracy and timeliness of documentation into client record (*Provide Enterprise*) for services provided.

Regulations

- Comply with state and federal regulations, including CDC Data Security and Confidentiality Guidelines for the following:
  - Eligibility
  - HIPAA
  - Confidentiality
  - Client Consent
  - Bill of Rights (or Rights and Responsibilities)
  - Data Security and Confidentiality
- Assure compliance with state and federal regulations, including CDC Data Security and Confidentiality Guidelines.
- Develop and implement the following: Ryan White Part B Eligibility Policy, HIPAA Privacy Policy, Confidentiality Policy, Data Security and Confidentiality Policy, Obtaining Client Consent and Client Bill of Rights (and/or Rights and Responsibilities),
  - Prior to staff access to confidential information, staff will complete training for:
    - HIPAA and Confidentiality
    - Data Security and Confidentiality

Grievance Policy and Procedures

- Grievance Policy and Procedures are required. They must be shared with clients. All staff must be aware of and adhere to the client grievance policy and procedures.
- Assure written grievance policy is shared with Ryan White Part B clients at the point of initial eligibility screening and annually thereafter. All attempts will be made to resolve the grievance at the agency level.
  - However, in accordance with the contract, the policy must state that any grievance related to a denial of services or a complaint about services received which is unresolved at the subrecipient level may be reported by the Client to DHEC's STD/HIV Division by calling the Division at 800-856-9954 between the hours of 8:30AM-5:00PM Monday-Friday, excluding holidays. Further, the policy must state that grievances filed with DHEC will remain confidential, unless the Client specifically requests that DHEC follow-up with the subrecipient, and there shall be no reprisal towards the Client when grievances are made.
- Develop and implement a client grievance policy and procedures. Ensure all staff are aware of and adhere to the client grievance policy and procedure. Ensure clients know the procedures.

Discharge and Re-Entry into Care

- Client Discharge and Re-Entry into Care (after Discharge) Policies and Procedures are required. Policies and procedures should include the process for client appeal if the Client was involuntarily discharged. All staff must be aware of and adhere to the Discharge and Re-Entry into Care (after Discharge) policy and procedures.
- Assure written Client Discharge and Re-Entry into Care (after Discharge) Policies and Procedures are developed. Assure staff is aware of the Policies and Procedures and follow them accordingly with proper documentation. Discharge and Reentry into Care decisions are to be determined by the agency. When possible, the agency should work with the Client or the RW Part B Program staff to ensure Client's

transition to another HIV Care provider, possibly through the use of Medical Case Management, payment for medical care, transportation services, or other core or supportive services.

- Develop and implement client discharge and reentry into care policies and procedures. Ensure all staff are aware of and adhere to the policies and procedures. Ensure proper documentation.

Productivity

- Productivity of all staff time charged to Ryan White must be for carrying out specific activities approved in the competitive Request for Grant Application, contract, and Implementation Plan. Staff time can only be charged to Ryan White for serving Ryan White eligible clients.
- Time and effort of staff working on Ryan White must be documented. The documentation must:
  - Be supported with documented payrolls
  - Reflect the distribution of activity of each employee when funded by multiple funding sources
  - Be supported by records indicating the total number of hours worked each day
  - Be supported by activity documented in EMR/EHR/ client record (*Provide Enterprise*)
- Review of documentation of employee time and effort, through:
  - Review of payroll records
  - Documentation of allocation of payroll between funding
  - sources if applicable
  - Review of time sheets or other documentation of hours worked each day
  - Documentation in EMR/EHR (if applicable), client record (*Provide Enterprise*)
- For example: Direct Service staff (excluding clinical staff) should strive to document in client record (*Provide Enterprise*) at least 75% of their Ryan White funded time. This equates to 7,200 minutes for a full time MCM employee working 40 hours per week.
- The provider must:
  - Maintain payroll record
  - Establish and consistently use an allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources
  - Make payroll records and allocation methodology available to grantee upon request
  - Establish time sheets or other documentation method to document all Ryan White funded staff hours worked each day
  - Strive for all Ryan White funded direct service staff (excluding clinical staff) document in PE at least 75% of Ryan White funded time.
  - Document in EMR/EHR, if applicable

QUALITY MANAGEMENT

Implementation of a Clinical Quality Management (CQM) Program to:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent HHS guidelines for the treatment of HIV/AIDS and related opportunistic infections
- Develop strategies for ensuring that services are consistent with the guidelines for improvement in the access to and quality of HIV health services

CQM program to include:

- A Quality Management Plan
- Quality expectations for providers and services
- A method to report and track expected outcomes
- Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved Service Standards

The state will provide periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the state under the Part B Program's approved Service Standards

Subrecipient Requirements

- Participate in quality management activities as contractually required, at a minimum:
    - Compliance with relevant service category definitions
    - Participation in QM Steering Committee meetings and activities for RW Part B funded providers
    - Annually updating and submitting to DHEC the Quality Management Plan
    - Annually submitting to DHEC the Clinical Report Card, which includes the established statewide Quality Management Performance Measures
    - Routinely monitoring agency performance utilizing Performance Management data and established targets
    - Implementing continuous quality improvement strategies to improve core and support services provided
    - Periodically updating DHEC as requested on implementation of improvement strategies Develop and monitor own Service Standards
- Documentation that the grantee has a Clinical Quality Management Program in place that includes, at a minimum:
    - A Quality Management Plan
    - Quality expectations for providers and services
    - Measurement of Outcome Indicators
    - Collection and Analysis of Data
    - Identification of improvement strategies
    - A method to report and track expected outcomes
- Monitoring of provider compliance with HHS treatment guidelines and the Part B Program's approved service category definition for each funded Service
- Review of CQM program to ensure that both the grantee and providers are carrying out necessary CQM activities and reporting CQM performance data
- Participation in QM Steering Committee meetings and activities for RW Part B funded providers
- Develop and monitor own Service Standards

ENDING THE HIV EPIDEMIC (EHE) INITIATIVE SERVICES

The federal Ending the HIV Epidemic in the U.S. (EHE) initiative focuses on reducing the number of new HIV infections in the United States by at least 90% by 2030, which would be fewer than 3,000 per year.

HRSA RWB EHE funding may be used not only for traditional RW core and supportive services, but also EHE Initiative Services and EHE Infrastructure.

EHE Initiative Services

Unique, non-traditional Ryan White Services employed to achieve EHE goals.

Samples in SC:

- Specialized linkage to care services for newly diagnosed and returning to care clients
- Medication starter packs to facilitate immediate prescription of antiretroviral therapies
- Testing, linkage, and immediate medical care via mobile unit
- Employment of technology to increase client retention and medication adherence
- Programs, trainings, and outreach to increase equitable, culturally appropriate access to HIV treatment and services

EHE Infrastructure

Investments in technological improvements to facilitate more efficient, high-quality care for people living with HIV.

EHE Eligibility

Subrecipients must certify that all clients served have documented HIV diagnoses; thereby meeting the singular eligibility requirement for EHE services.

More information about HRSA's EHE Initiative can be found here.

CORE SERVICES

Early Intervention Services (EIS)

Early Intervention Services (PCN 16-02) is the combination of such services rather than a standalone service. RWHAP Part B recipients are expected to provide each activity, as stated in the specific service categories.

Clients with two positive HIV immunoassays (rapid tests) are eligible for Ryan White Part B services.

EIS include identification of individuals at points of entry and access to services and provisions of:

- HIV Testing and Targeted counseling
- Referral services
- Linkage to care
- Health education and literacy training that enable clients to navigate the HIV system of care

All four components must be present; however, Part B funds can be used for HIV testing only as necessary to supplement, not supplant, existing funding.

- Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate, and Ryan White funds will supplement and not supplant existing funds for testing
- Individuals who test positive for HIV are referred for and linked to health care and supportive services within 30 days of positive test results
- Health education and literacy training is provided that enabling clients to navigate the HIV system
- EIS is provided at or in coordination with documented key points of entry
- EIS services are coordinated with HIV prevention efforts and programs

Part B subrecipients may implement a rapid-rapid testing policy, ensuring faster linkage to core and support services. (More information is available through DHEC's HIV Prevention Program

Key Service Components and Activities

- **Targeted HIV testing** to help the unaware learn of their HIV status and receive a referral to HIV care and treatment services if found to be HIV-positive.
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
- **Referral services** to improve HIV care and treatment services at key points of entry and direct a client to needed core medical or support services in person or through telephone, written, or other type of communication.

- **Access and linkage to HIV care and treatment services within 30 days of services.** Such treatment services include HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care.
- **Outreach Services and Health Education/Risk Reduction:**
    - **Outreach Services:**
        - Are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort.
        - Target populations known to be at disproportionate risk for HIV infection.
        - Target communities whose residents have disproportionate risk or establishments frequented by individuals exhibiting high-risk behaviors.
        - Are designed so that activities and results can be quantified for program reporting and evaluation of effectiveness.
    - **Health Education/Risk Reduction services** that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes providing clients with the following:
        - Information about available medical and psychosocial support services.
        - Education on HIV transmission and how to reduce the risk of transmission.
        - Counseling on how to improve their health status and reduce the risk of HIV transmission to others.
        - Peer Adherence Services that involves conducting service literacy activities to increase client awareness of service options and emphasize the importance and accessibility of care and treatment services.

Subrecipient Requirements

- Establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive.
- Establish linkage agreements with testing sites where Part B is not funding testing but is funding referral and access to care, education, and system navigation services.
- Obtain written approval from the grantee to provide EIS services in points of entry not included in original scope of work.
- Maintain Documentation of:
    - Provision of all four required EIS service components, with Part B or other funding.
    - Numbers of HIV tests and positives, as well as where and when Part B-funded HIV testing occurs.
    - Part B funds are only used where existing federal, state, and local funds are not adequate.
    - HIV testing activities and methods meet CDC and state requirements, including staff credentials.
    - The number of referrals for health care and supportive services.
    - Referrals from key points of entry to EIS programs.
    - Training and education sessions designed to help individuals navigate and understand the HIV system of care.

Health Insurance Premium and Cost-Sharing Assistance

Health Insurance Premium and Cost-sharing Assistance (PCN 16-02) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance.

Allowable Costs Include

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients
- Paying cost sharing on behalf of the Client
- Co-pays for prescription eyewear*

Subrecipient Requirements

- Provides a cost-effective alternative to ADAP
- Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low-income clients that provide a full range of HIV medications
- Providing funds to contribute to a client's Medicare Part D true out-of-pocked (TrOOP) costs
- Enroll clients into the ADAP Insurance Assistance Program (IAP) for premium payments and copay and deductible payments for medications on the ADAP formulary.
- Contact ADAP Program for more information regarding ADAP Insurance enrollment requirements.
- In cases where premiums are covered by Ryan White funds (not ADAP funds), conduct an annual aggregate cost benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low-income clients, compared to the costs of having the Client in the ADAP program using your contracted pharmacy drug pricing rates for comparison.
- An annual cost-benefit analysis illustrating the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays and or deductibles for eligible low-income clients, compared to the costs of having the Client in the ADAP program
- Where premiums are covered by Ryan White funds (not ADAP funds), provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications
- Where funds are covering premiums, documentation that the insurance plan purchased provides comprehensive primary care and a full range of HIV medications
- Apply Client to low-income subsidy if Client's status meets criteria as defined by the State Ryan White Program. Must maintain proof of low-income status
- Assure that any cost associated with the creation, capitalization, or administration of a liability risk pool is not being funded by Ryan White
- Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization or administration of a liability risk pools, or social security costs

*Ryan White Part B funds can be used to cover co-pays for prescription eyewear. Where Ryan White Part B funds are used to cover co-pays for prescription eyewear, documentation including a physician's written statement that the eye condition is related to HIV infection.

Home and Community-Based Health Services

Home and Community-Based Health Services (PCN 16-02) are provided to an eligible client in an integrated setting appropriate to that Client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

Allowable Costs Include

- Durable medical equipment

- Home health aide and personal care services
- Day treatment or other partial hospitalization services
- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy)
- Routine diagnostic testing
- Appropriate mental health, developmental, and rehabilitation services
- Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities

Unallowable Costs Include

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

Subrecipient Requirements

- Staff must be licensed by the State of South Carolina and certified to provide home and community-based services
- Assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services.
- Maintain Documentation of:
    - All services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services
    - All planned services are allowable within the service category
    - Specifies the types, dates, and location of services
    - Includes the signature of the professional who provided the Service at each visit
    - Indicates that all services are allowable under this service category
    - Ensure that written care plans with appropriate content and signatures are consistently prepared, included in client records (*Provide Enterprise)*, and updated as needed.
    - Establish and maintain a program and client record (*Provide Enterprise)* keeping system to document the types of home services provided, sates provided, the location of the Service, and the signature of the professional who provided the Service at each visit
    - Make available to the grantee program files and client records (*Provide Enterprise)* as required for monitoring
    - Provide assurance that the services are being provided only in an HIV-positive client's home
    - Maintain, and make available to the grantee on request, copies of appropriate licenses and certifications for professionals providing services

Home Health Care Services

Home Health Care (PCN 16-02) is the provision of medical services to persons that are homebound and are performed by licensed professionals. Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a physician.

Allowable Costs Include

- Administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care

- Routine diagnostics testing administered in the home
- Other medical therapies

Unallowable Costs Include

- Durable medical equipment
    - Oxygen
    - Home health aide services
    - Physical/occupational or speech therapy Nursing facilities
- Inpatient mental health/substance abuse treatment facilities

Subrecipient Requirements

- Maintain on file and provide to the grantee on request copies of the licenses of home health care worker. Click here to verify licensure
- Staff must be licensed by the State of South Carolina and certified to provide skilled nursing services
- The agency provided home health services must be licensed and certified as a Home Health Agency by the State of South Carolina.
    - Agency must show evidence of professional malpractice insurance in addition to insurance requirements of the State of South Carolina
- Maintain on file and provide to the grantee on request copies of the licenses of home health care workers. Information on home health agencies can be found here
- Plan of care must be coordinated by Client's clinical care team
- Document the number and types of services in the client records (*Provide Enterprise)*, with the provider's signature included

Note: Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Medical Case Management

Medical Case Management, including Treatment Adherence Services (PCN 16-02) Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan

State-specific guidance and requirements can be found here.

Medical Nutrition Therapy Services

Medical Nutrition Therapy (PCN 16-02) All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other

licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP.

Allowable Costs Include

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

Unallowable Costs Include

- Activities not provided by a registered/licensed dietician should be considered ***Psychosocial Support Services*** under the HRSA RWHAP

Subrecipient Requirements

- Referral for medical nutrition therapy services by a medical provider
- Medical nutrition therapy plan/activities provided by a registered/licensed dietician as required by the state in which the Service is provided
- Evaluations to be offered to each client yearly
- Required content of the nutritional plan, includes:
    - Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food
    - Date service is to be initiated
    - Planned number and frequency of sessions
    - The signature of the registered dietician who developed the plan
- Services provided, including Nutritional supplements and food provided, quantity, and dates; The signature of each registered dietician who rendered Service, the date of Service; Date of reassessment; Termination date of medical nutrition therapy; Any recommendations for follow up
- Maintain Documentation of:
    - Copy of referral, for medical nutrition therapy, on file in Client's medical record which includes written order, diagnosis and desired nutrition outcomes as indicated per Client's condition
    - Maintain and make available to the grantee copies of the dietician's license and registration
    - Nutritional plan, as required, on file in Client's medical record including required information and signature of the registered dietician who developed the plan
    - Document services provided, number of clients served, and quantity of nutritional supplements and food provided to clients
    - Document in each client file: Services provided and dates

Mental Health Services

Mental Health Services (PCN 16-02) are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Allowable Costs Include

- Outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services

- Mental Health Services are allowable only for PLWH who are eligible to receive HRSA RWHAP services

Subrecipient Requirements

- Medical Case Managers, or designated staff, are only responsible for completing the mental health screening/assessment located in the Intake and Reassessment, unless otherwise stipulated by your agency, and must refer Client to mental health provided for services
    - Referral and follow-up for closure of referral must be in client record (*Provide Enterprise*)
- Ensure contracted staff have current mental health professional license to provide such services (group or individual)
- **Assessment/Reassessment:**
    - Client assessment should be completed by licensed mental health provider and take place yearly and should be comprehensive
        - Assessments and Treatment Plans should be developed concurrently and collaboratively with the Client
        - Clients should be periodically reassessed, based on Client need to ensure the relevancy of the treatment plan
    - Reassessment is ongoing and driven by client need, when a client's status has changed significantly, or when the Client has left and re-entered treatment or at a minimum of every twelve months
- **Treatment Plan/Continuum of Care:**
    - The sub-recipient who provides mental health treatment must assess on an ongoing basis the need for other mental health programs that may better meet Client's clinical needs and provide appropriate referrals. These referrals may include day programs, inpatient psychiatric units, community mental health programs, etc.
    - Treatment planning should take place before the actual delivery of services and should be relevant to the current situation of the Client
    - The sub-recipient who provides mental health treatment must maintain ongoing contact and follow-up with Client's medical case manager, medical provider, and/or other psychosocial providers.
    - The sub-recipient mental health provider must review and update the treatment plan every 6 months or on an as needed basis
    - Treatment plans should be finalized within two weeks of the completion of the Assessment and developed by the same mental health provider that conducts the Assessment; OR
    - Client charts will have Client's treatment plan completed within 30 days of intake.
- **Case Closure, Referral and Discharge**
    - Clients should not be terminated from mental health care until it is clear they no longer need or desire the services
        - Regular follow-up will be provided to clients who have dropped out of treatment without notice
        - A Case Closure Summary shall be completed for each Client who has terminated treatment
    - The sub-recipient who provides mental health treatment must consult with supervisor to decide that a client is to be discharged
    - After a decision has been made to discharge Client, the mental health treatment provider must complete a discharge within 14 days
    - The sub-recipient who provides mental health supervision must review and sign the discharge summary

- Maintain Documentation of
    - Appropriate and valid licensure and certification of mental health professionals available for grantee review
    - Ongoing assessment of needs and appropriate referrals in client record (*Provide Enterprise*)
    - Client service plans are closed out when they are met/deferred
    - Attempts to contact Client should be noted by a progress note in client record (*Provide Enterprise*).
    - The following should be kept in Client's mental health file (not *Provide Enterprise*):
        - Statement of Client's presenting problem
        - Psychiatric or mental health treatment history
        - Family, relationships, and support systems
        - Cultural influences
        - Education and employment history
        - Substance use history
        - Legal history
        - General and HIV related medical history
        - Medication adherence
        - HIV risk behavior and harm reduction
        - Mental status exam
        - Complete DSM V diagnosis
        - Statement of problem
        - Goals and objectives
        - Interventions and modalities
        - Frequency of Service
        - Recommended number of sessions
        - Referrals
        - Projected treatment end date,
        - Any recommendations for follow up
        - The signature of the mental health professional rendering services
        - If Client is closed, Client's mental health file will include signed and dated Case Closure Summary to include:
            - Course of treatment
            - Discharge diagnosis
            - Referrals made
            - Reason for termination
            - If the person closing the case was not licensed, the client file must demonstrate review and sign-off by a clinical supervisor

Oral Health Services

Oral Health Services (PCN 16-02) includes outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Allowable Costs Include

- Outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants

Unallowable Costs Include

- Cosmetic or orthodontic services (examples may include the following: porcelain caps, veneers, orthodontia cosmetic braces, and tooth whitening.)

Performance Measures:

- % of clients will have a dental treatment plan in the measurement year
- % of clients with VL <200 in the measurement year

Subrecipient Requirements

- The following must be included in the client record (*Provide Enterprise)* for every dental Service (internal and external):
    - The referral
    - Treatment plan
    - Follow-up for closure of referral
- For agency who have on-site dental clinics, agency must maintain a dental file for each Client and must be signed by the licensed provider.
    - A treatment plan
    - Services provided
    - Any referrals made
- Maintain and provide to grantee on request, copies of professional licensure and certification
- Maintain Documentation of:
    - Oral health services are provided by general dental
    - Practitioners, dental specialists, dental hygienists, and auxiliaries and meet current dental care guidelines
    - Oral health professionals providing the services have appropriate and valid licensure and certification, based on State and local laws
    - An oral health treatment plan is developed to include costs of procedures, for each eligible Client and signed by the oral health professional rendering the services; Treatment plan and costs will be approved by RW Part B provider prior to services provided.

Outpatient and Ambulatory Medical Care Services

Outpatient and Ambulatory Medical Care (OAMC) (PCN 16-02) is defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Allowable Services Include

- Diagnostic testing
- Early intervention and risk assessment
- Preventive care and screening
- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions
- Prescribing and managing of medication therapy
- Education and counseling on health issues
- Well-baby care
- Continuing care and management of chronic conditions

- Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)

Medical Care Services cannot be conditioned upon where medical case management services and related services are provided.

Subrecipient Requirements

- Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection
- Include clinician notes in patient records that are signed by the licensed provider of services
- Maintain professional certifications and licensure documents and make them available to the grantee on request
- Care must be consistent with HHS Guidelines
- Maintain Documentation of:
    - Care is provided by health care professionals certified in their jurisdictions to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van
    - Only allowable services are provided
    - Services are provided as part of the treatment of HIV infection
    - Specialty medical care relates to HIV infection and/or conditions arising from the use of HIV medications resulting in side effects
    - Services are consistent with HHS Guidelines
    - Service is not being provided in an emergency room, hospital, or any other type of inpatient treatment center

As part of ***Outpatient and Ambulatory Medical Care***, provision of **laboratory tests** integral to the treatment of HIV infection and related complications

Subrecipient Requirements

- Maintain Documentation of:
    - Client medical records, and make available to the grantee on request:
        - The name and number of laboratory tests performed
        - The certification, licenses, or FDA approval of the laboratory from which tests were ordered
        - The credentials of the individual ordering the tests (only licensed medical provider ordered labs)
    - Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider
    - Consistent with medical and laboratory standards
    - Approved by the Food and Drug Administration (FDA) and/or Certified under the Clinical Laboratory Improvement Amendments (CLIA) Program

Substance Abuse Treatment – Outpatient

Substance Abuse Treatment (Outpatient) (PCN 16-02) Care is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Substance abuse treatment is the application of general counseling theories and treatment methods adopted specifically for alcohol and drug theory and research for the express purpose of treating alcohol and drug problems (6 CCR 1008-3). Only appropriately licensed facilities may provide substance abuse treatment.

"Service unit" is defined as treatment session, delivered either one-on-one or in a group format. For each day, only one visit across interventions of substance abuse services may be counted.

Allowable Costs Include

- Pre-treatment/recovery readiness programs
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Acupuncture Therapy*
- Neuro-psychiatric pharmaceuticals
- Relapse prevention

Subrecipient Requirements

- Assurance that services provided include a treatment plan that calls for only allowable activities and includes:
    - The quantity, frequency, and modality of treatment provided
    - The date treatment begins and ends
    - Regular monitoring and assessment of client progress
    - The signature of the individual providing the Service and or the supervisor as applicable
- Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the state in which services are provided
- Clients will be placed in a level of substance abuse treatment consistent with placement criteria established by the American Society of Addiction Medicine (ASAM PPC-2R**)
- Substance abuse treatment should be available in both ASAM nonresidential levels of care, being responsive to the diversity of needs of clients
- Substance abuse treatment should be guided by biopsychosocial assessment and individualized treatment plans
- Substance abuse treatment programs should include an assessment of interactions with HIV medications and should be linked to a client's HIV medical provider
- Level 1 programs are strongly encouraged to have active affiliations with other levels of care. Such affiliations are required for Level 2 programs
- Consistent with ASAM criteria for continued Service and discharge, services should continue so long as continued service criteria are met and should be discharged or transferred when discharge/transfer criteria are met
- Assurance that services are provided only in an outpatient setting Assurance that Ryan White funds are used to expand HIV-specific capacity of programs only if timely access would not otherwise be available to treatment and counseling
- Maintain Documentation of:
    - Provider licensure or certifications as required by the state in which Service is provided.
    - Provide assurance that all services are provided on an outpatient basis
    - The client record (*Provide Enterprise)* should include:
        - Referral and follow-up for closure of referral
        - Progress notes should document ongoing communication with a client's medical provider, as appropriate

        - That placement was consistent with the findings of licensed professional provider
    - Maintain program files that include treatment plans with all required elements and document:
        - That all services provided are allowable under Ryan White
        - The quantity, frequency, and modality of treatment services
        - The date treatment begins, and ends
        - Regular monitoring and assessment of client progress
        - The signature of the individual providing the Service or the supervisor as applicable
    - The funded system of substance abuse treatment must include Level 1 and Level 2 services (or a SCDHEC approved equivalent)
        - The ASAM level of care should be documented.
    - Memoranda of Understanding or other evidence of affiliation should be available in Level 2 programs

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

**The criteria/dimensions set by ASAM are:

- Alcohol intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral, or cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential

The ASAM Levels of Care are:

- Level 1 – Outpatient treatment
- Level 2 – Intensive outpatient treatment

Biopsychosocial assessments should utilize an evidence-based approach.

Treatment plans should include problem statements, treatment goals, and measurable objectives. Such plans should be developed in consultation with the patient.

Progress notes should document that treatment was delivered consistent with the treatment plan.

The treatment plan should address potential drug interactions.

When warranted, clients should be linked or actively referred to other levels of care.

ASAM criteria for continued Service are:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan OR
- The patient is not yet making progress but has the capacity to resolve his or her problems OR
- New problems have been identified that are appropriately treated at the present level of care

ASAM criteria for discharge/transfer are:

- The patient has achieved the goals articulated in the treatment plan OR
- The patient has been unable to resolve the problems that justified admission to the present level of care, despite amendments to the treatment plan, indicating another level of care is needed OR
- The patient has demonstrated a lack of capacity to resolve his or her problems, indicating another level of care is needed OR

- The patient has experienced an intensification of his or her problems or has developed a new problem and can be treated effectively only at a more intensive level of care

SUPPORT SERVICES

Child Care Services

Child Care Services (PCN 16-02) supports intermittent Child Care Services for the children living in the household of PLWH who HRSA RWHAP-eligible clients for the purpose of are enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable Costs Include

- Child Care Services for the children of HIV-positive clients, provided intermittently, only while the Client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions
- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)
- May include Recreational and Social Activities for the child, if provided in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities

Unallowable Costs Include

- Excludes use of funds for off premise social and/or recreational activities
- Direct cash payments to clients are not permitted

Subrecipient Requirements

- Appropriate liability release forms obtained that protect the Client, provider, and the Ryan White program
- Such allocations to be limited and carefully monitored to assure:
    - Compliance with the prohibition on direct payments to eligible individuals
    - Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the Client, provider, and the Ryan White Program
- Documentation in the Client's primary record must reflect the appointment and/or meeting/group/training session attended
- Maintain documentation of:
    - No cash payments are being made to clients or primary care givers
    - Payment is for actual cost of Service
    - Compliance with grantee-required mechanism for handling payments for informal childcare arrangements
    - Appropriate licensure credentials of all individuals provide childcare service
    - Date and duration of each unit of childcare service provided o Determination of client eligibility
    - Reason why childcare was needed – e.g., client medical or other appointment or participation in a Ryan White-related meeting, group, or training session
    - Any recreational and social activities, including documentation that they were provided only within a certified or licensed provider setting
    - Signed and dated reports verifying need, documenting assistance provided and method of providing EFA in the Client's record

- Where provider is a childcare center or program, make available for inspection appropriate and valid licensure or registration as required under applicable State and local laws

Emergency Financial Assistance Services (EFA)

Emergency Financial Assistance (PCN 16-02) provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes.

Allowable Costs Include

- Utilities
- Housing
- Food (including groceries and food vouchers)
- Transportation
- Medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes
- Prescription eyeglasses

Unallowable Costs Include

- Direct cash payments to clients are not permitted
- Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance

Service Limitations

- Each Subrecipient will provide service caps that reflect their funding amount and fair market rent utility prices of their service area.

Subrecipient Requirements

- Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program
- Emergency funds are allocated, tracked, and reported by type of assistance to include:
  - Number of clients and amount expended for each type of EFA
  - Summary of number of EFA services received by Client
  - Methods used to provide EFA (e.g., payments to agencies, vouchers)
- Ryan White is the payer of last resort
- Documentation of EFA provided by type of assistance.
- Maintain Documentation of:
  - Client eligibility and need for EFA
  - Types of EFA provided
  - Date(s) EFA was provided
  - Method used to provide EFA (e.g., vouchers, payments to agencies). Note: Direct cash payments to clients is not permitted
  - All reports must be signed and dated
  - Signed and dated reports verifying need, documenting assistance provided and method of providing EFA in the Client's record

Food Bank and Home-Delivered Meals

Food Bank/Home-delivered Meals (PCN 16-02) refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited

to personal hygiene products, household cleaning supplies, water filtration/purification systems in communities where issues of water safety exist.

Allowable Costs Include

- Actual food items
- Nutritional supplements*
- Hot meals
- A voucher/gift card program to purchase food
- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Unallowable Costs Include

- Household appliances
- Pet foods
- Alcohol, tobacco, illegal drugs, or firearms
- Other non-essential products
- Vouchers/gift cards may not be redeemed for cash

Subrecipient Requirements

- Follow and disseminate policy and procedures for use of vouchers/gift cards and keep
- Develop and keep policy to ensure security of vouchers/gift cards
- Follow limitation on usage guidelines and keep on file documentation that the services provided are limited to the allowable usage categories
- Ensure both staff and clients are made aware of and provided a copy of policies and procedures related to distribution of vouchers/gift cards
- Maintain food bank/home-delivered meal service records for each Client served and document services as a case note with corresponding service unit** and in Care Plan, as needed
    - Ensure client records (*Provide Enterprise)* include evidence of client signature acknowledging the use of the voucher/gift card policy and include:
        - Date client received assistance
        - Documentation that the Client meets eligibility criteria
        - Copy of check or Voucher/gift card
- Maintain records that reflect compliance with the food bank/home delivered meals standards outlined above and should be complete, accurate, confidential, and secure

*Nutritional supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician should be included in food bank expenditures. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP. Please refer to Service Standard: ***Medical Nutrition Therapy***.

**Service units of food bank are defined as an instance of a client receiving food, a voucher/gift card for food, or other resources allowable under this services category and are documented per Service provided as "food bank/home-delivered meal" in Provide Enterprise, with corresponding dollar amount, if necessary.

Health Education and Risk Reduction Services

Health Education/Risk Reduction Services (PCN 16-02) refers to the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status.

Allowable Costs Include

- Education on risk reduction strategies to reduce transmission such as Pre-Exposure Prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Education on HIV transmission and how to reduce the risk of transmission
- Counseling on how to improve their health status and reduce the risk of HIV transmission to others
- Health Literacy
- Peer Adherence Services
- Treatment Adherence Education

Subrecipient Requirements

- Referral for Health Education Risk Reduction Services by a Part B Provider is documented prior to initiation of the Service.
- An initial health education/risk reduction assessment is completed prior to the initiation of the Health Education/Risk Reduction (HE/RR) plan.
- Within 45 days of initial assessment, a HE/RR plan is developed in the Action Plan for each eligible Client. The plan should include:
    - Goals
    - Expected outcomes
    - Actions taken to achieve each goal
    - Staff responsible for completing each action
- Target date for completion of each action
- HE/RR plan is reassessed every 90 days to assess client progress and identify emerging needs
- Clients living with HIV are educated about HIV transmission and how to reduce the risk of HIV transmission, STDs, and opportunistic infections
- Clients living with HIV receive counseling on how to improve their health status and reduce the risk of HIV transmission to others
- Clients living with HIV receive counseling on condoms, PEP and PrEP
- Refer Client to other services as Appropriate (i.e., mental health, substance abuse treatment, condoms, PEP, HIV Testing of partners, etc.)
- Refer Client to Peer Adherence Services as appropriate and as needed
- Maintain Documentation of:
    - Referral for Health education Risk reduction Services is present in the Client's record, signed and dated by provider
    - Assessment in Client's record signed and dated by provider
    - HE/RR plan, documented in client record (*Provide Enterprise)*, signed, and dated by the Client and provider
    - Review and update of HE/RR plan as appropriate signed and dated by Client and provider
    - Clients served under this category is educated about HIV transmission and how to reduce the risk of HIV transmission to others. Includes description of the types of information, education, and counseling provided to clients

- Clients served under this category receives counseling on how to improve their health status and reduce the risk of HIV transmission to others. Includes description of the types of information, education, and counseling provided to clients
- Clients served under this category receives counseling on how to prevent HIV transmission and reduce the risk to others
- Referrals in Client's PE record

Housing Services

Housing Services (PCN 16-02) provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the Client's linkage to permanent housing. Housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder services).

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

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

Housing, as described here, replaces PCN 11-01.

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

Allowable Costs Include

- Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, State, and federal housing programs can be accessed; or
- Short-term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either:
    - Housing services that include some type of medical or supportive Service: including, but not limited to, residential substance treatment or mental health services (not including facilities classified as an Institution for Mental Diseases under Medicaid), residential foster care, and assisted living residential services;
    - Housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment; necessity of housing service for purposes of medical care must be certified or documented
- Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation

- Housing funds cannot be in the form of direct cash payments to recipients or services and cannot be used for mortgage payments

Subrecipients in South Carolina may provide short term or emergency housing assistance to clients for 21 weeks, and transitional housing assistance for 24 months.

Service Limitations

- Each Subrecipient will provide service caps that reflect their funding amount and fair market rent utility prices of their service area.

Unallowable Costs Include

- Housing activities cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments or rental deposits, **although these may be allowable costs under the HUD Housing Opportunities for Persons with AIDS grant awards**

Subrecipient Requirements

- Housing related referrals are provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs
- For all housing, regardless of whether the Service includes some type of medical or supportive services:
- Each Client receives assistance designed to help him/her obtain stable long-term housing, through a strategy to identify, re-locate, and/or ensure the individual or family is moved to or capable of maintaining a stable long-term living situation
- Housing services are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment
- Mechanisms are in place to allow newly identified clients assess to housing services
- Policies and procedures to provide to provide individualized written housing plan, consistent with this Housing Policy, covering each Client receiving short term, transitional and emergency housing services
- No funds are used for direct payments to recipients of services for rent or mortgages
- Maintain Documentation of:
    - Funds are used only for allowable purposes
    - Housing-related referral services including housing assessment, search, placement, advocacy, and the fees associated with them
    - Services provided including number of clients served, duration of housing services, types of housing provided, and housing referral services
    - Client eligibility
    - Housing services, including referral services provided
    - Mechanisms are in place to allow newly identified clients access to housing services
    - Individualized written housing plans are available, consistent with this Housing Policy, covering each Client receiving short-term, transitional, and emergency housing services
    - Assistance provided to clients to help them obtain stable long-term housing
    - That no Ryan White funds are used to provide direct payments to clients for rent or mortgage

Linguistic Services

Linguistic Services (PCN 16-02) include interpretation and translation activities, both oral and written to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the Client. These services are to be provided when such services

are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

"Service units" of Linguistic Services are defined as an instance of a client receiving interpretation or translation services and are documented per Service provided as "linguistic services" in client record (*Provide Enterprise*).

Subrecipient Requirements

- Part B providers must assure the competence of language assistance provided to clients limited in English proficiency by interpreters and bilingual staff. Family and friends should not be used to provide translation services (except on request by the patient/consumer).
- Part B providers ensure access to services for clients with limited English skills in one of the following ways:
    - Bilingual staff who can communicate directly with clients in preferred language
    - Face-to-face interpretation provided by qualified staff, contract interpreters, or volunteer interpreters
    - Telephone interpreter services.
- If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent. The family member or friend must be able to communicate fluently in both English and the native language of the Client.
- Working collaboratively with the Client and/or Client's support person, the Part B provider assesses Client's interpretation and/or translation needs.
- The Part B provider assesses Client's interpretation and/or translation needs or when there is an access barrier.
- The Part B provider and Client identify appropriate method to access services (i.e., telephone interpretation, bilingual staff member, etc.).
- Working collaboratively with the Client and/or Client's support person, the Part B provider assesses the appropriate method to access interpretation services
- Volunteers will receive appropriate orientation, training, and supervision. All volunteers will be given orientation prior to providing services and will be supervised by qualified program staff
- Part B providers will maintain a release of information signed by the Client.
- Linguistic Services records will reflect compliance with the standards outlined above. Records should be complete, accurate, confidential, and secure.
- Maintain Documentation of:
    - Access to services for clients with limited English skills through the following:
        - For bilingual staff, résumés on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting
        - Copy of certifications on file for contract or volunteer interpreters
        - Listing/directories on file for telephone services
        - Family/friend interpretation consent form signed by the Client and maintained in Client's file
    - Assessment in client progress logs in client record (*Provide Enterprise*)
    - Orientation curriculum on file at provider agency
    - Orientation curriculum reviewed by DHEC prior to implementation
    - Evidence of:
        - Volunteer Application
        - Training
        - Supervision
    - Signed and dated form on file that outlines responsibilities, obligations, and liabilities of
    - each volunteer

- Signed release of information is present in Client's file
- Linguistic Services records include:
  - Date client received assistance
  - Documentation that the Client meets eligibility criteria
  - Copy of check or voucher, if applicable.
- Linguistic services will be documented as a Progress Log and Service Provided in client record (*Provide Enterprise*), with corresponding service unit and dollar amount, as applicable

Medical Transportation Services

Medical Transportation Services (PCN 16-02) refers to the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Allowable Costs Include

- Contracts with providers of transportation services may include, but not limited to Uber Health, Lyft, etc.
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the state rate per mile for reimbursement
- Purchase or lease of agency vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle (More cost effective to purchase)
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher, gas cards and bus pass systems, that allows for tracking and distribution
  - The purchase of Gift Card/Certificate and Pre-Paid Card Purchases, and other items of monetary value are usually unallowable expenses for both federal and state funds.
  - If allowable, the purchase of these items must be limited and strictly monitored.

Unallowable Costs Include

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments,
- insurance, license, or registration fees.

Subrecipient Requirements

- The Subrecipient must obtain written pre-approval from the DHEC Program Area prior to purchase.
  - The Subrecipient must submit to the DHEC Program Area, a written request and justification to purchase any gift cards/certificate, pre-paid card, etc. or other items of monetary value. The justification should include:
    - Reason for the purchase- what is the gift card being used for
    - Known recipients or target recipients
    - Number of cards/certificates to be purchased
    - Value of each card/certificate
    - Total purchase price
    - How the cards will be disbursed/distributed
    - Evidence of a tracking system
- A referral by a Ryan White Part B provider is made for initiation of transportation services.
- The Client's eligibility for Ryan White Part B services are determined or is in process of determination prior to services being initiated.
- All medical transportation services provided for clients are documented.

- Voucher/Gas Cards/Bus Pass Systems:
    - Agency will have procedures in place regarding allowable uses and distribution of vouchers, gas cards and bus passes
    - Agency will have a tracking system in place to account for the purchase and distribution of vouchers, gas cards and bus passes
    - Agency will have a security system in place for storage of and access to vouchers, gas cards and bus passes
- Patients will be notified of transportation cancellations in a timely manner. Alternative transportation services will be provided as available.
- Transportation agency will be notified by patient and/or provider of transportation cancellations and changes in scheduling as they occur.
- Direct Transportation – Providers of Transportation Services:
    - Direct Transportation Providers delivering nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.
    - Clients are provided with information on transportation services and instructions on how to access the services.
    - General transportation service hours
    - Agency must allow clients to confirm core or support service appointments at least 24-48 hours in advance.
    - Agency provides clients with information on transportation limitations, clients' responsibilities for accessing and receiving transportation, and the agency's role and responsibilities for providing transportation services.
    - Clients initiate and coordinate their own services with transportation providers following client orientation to the agencies transportation policies, procedures, and client guidelines. Advocates (i.e., case manager) for the Client may assist clients in accessing transportation services if needed.
    - All clients will be screened for other transportation resources (i.e., Medicaid-eligible clients.)
    - Accommodations are provided for related/affected individuals and/or caregivers as necessary for the benefit of the Client.
    - Client consent to transportation services and agreeing to safe and proper conduct in the vehicle is on file in the client record (*Provide Enterprise)*. Consent includes the consequences of violating the agreement, (i.e., such as removal, suspension and/or possible termination of transportation services, as a last resort).
    - Agency/Driver may refuse Service to any client with open sores/wounds where blood and other body fluids from clients are potentially infectious. Driver to notify the agency immediately relating to any driver refusal to provide services.
    - Clients and agencies are made aware of problems immediately (i.e., vehicle breakdown, etc.) and notification documented.
    - Clients and Ryan White/State Services providers are notified of transportation service delays and changes in appointments or schedules as they occur.
- Agency must document Trip Origin and Trip Destination (i.e., city to city, Client's home to clinic).
- Volunteer Drivers provide nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.
- Agency purchase or lease of agency vehicles:
    - Proof of prior approval from HRSA/HAB to include RW-B, to lease or purchase vehicle

    - Purchased or leased vehicles provide nonemergency transportation services that enable an eligible client to access or be retained in core medical and support services.
- Maintain Documentation of:
    - Referral by a Ryan White Part B provider is present in the Client's record, signed and dated.
    - Client's eligibility or that the eligibility process has been initiated and is present in the Client's record.
    - Purpose for all transportation services provided (i.e., transportation to/from what type of medical or support service appointment). Documented and dated in the client record (*Provide Enterprise)* by designated staff.
    - Transportation transaction in patient's record signed and dated by designated staff includes:
        - Client eligibility
        - Type of transportation service used to meet Client's need
        - The level of Service (i.e., the number of trips, vouchers, gas cards and bus passes provided to the Client)
        - The trips relation to supporting health and support services
        - Trip origin and destination
        - Cost per trip
    - Cancellation and referral to alternative transportation source in patient's record signed and dated by designated staff.
    - Changes and cancellations in patient's record signed and dated by designated staff.
    - A signed statement from Client consenting to transportation services and agreeing to safe and proper conduct in the vehicle is on file.
    - Client received orientation to accessing transportation services in client record (*Provide Enterprise)*.
    - Contract with provider of transportation services on file at RW Part B service agency
    - Defines transportation in terms of allowable services and methods of delivery
    - Defines cost methodology for contracted
    - Transportation services illustrating the contracted provider(s) for direct transportation services is meeting stated contract requirements regarding methods of providing transportation.

Non-Medical Case Management Services

Non-Medical Case Management Services (PCN 16-02) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services.

Non-Medical Case Management Services provide guidance and assistance in improving access to needed services whereas Medical Case Management services improve health care outcomes.

Non-medical case managers must have completed the training for medical case management and participate in annual HIV prevention and care related trainings. Direct supervisors of non-medical case managers must have completed the training for medical case management and participate in annual HIV prevention and care related trainings. Training certificates/records should be kept for all appropriate staff.

Allowable Costs Include

- Coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services
- Assisting eligible clients in obtaining access to public and private programs for which they may be eligible (i.e., Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor, Education-

funded services, other State or local health care and supportive services, private health care coverage plans)

- All types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication)
- Key activities include:
    - Initial assessment of service needs
    - Development of a comprehensive, individualized care plan
    - Timely and coordinated access to medically appropriate levels of health services, support services, and continuity of care
    - Client-specific advocacy and/or review of utilization of services
    - Continuous client monitoring to assess the efficacy of the care plan HIV/AIDS BUREAU POLICY 16-02 21
    - Re-evaluation of the care plan at least every 6 months with adaptations as necessary
    - Ongoing assessment of the client's and other key family members' needs and personal support systems

Subrecipient Requirements

- Provide assurances that any transitional case management for incarcerated persons is provided as part of discharge planning
- Maintain Documentation of:
    - Client records (*Provide Enterprise)* include the required elements, including:
        - Date of encounter
        - Type of encounter
        - Duration of encounter
        - Key activities, including benefits/entitlement counseling and referral services
    - Scope of activity that includes advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services
    - Where benefits/ entitlement counseling and referral services are provided, they assist clients in obtaining access to both public and private programs, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services
    - Services cover all types of encounters and communications (e.g., face-to-face, telephone contact, other)
    - If transitional case management is provided for incarcerated persons, assurance that such services are provided either as part of discharge planning or for individuals who are in the correctional system for a brief period
    - An action plan is developed collaboratively with the Client that addresses the identified need(s) along with providing referrals/resources
    - The non-medical case manager must address clients' barriers to access necessary resources.
    - The non-medical case manager must conduct follow-up to referrals/resources within 10 business days of creating the action plan
    - The non-medical case manager assists the Client to obtain core medical and support services.
    - If additional problems or needs develop, it is the responsibility of the Client to notify the non-medical case manager
    - Transition and Discharge information*

***Transition and Discharge:** Discharge is a systematic process that occurs when the consumer no longer requires case management services or when the consumer and case manager are unable to work in partnership. The purpose of discharge is to assure the consumer as smooth a transition as possible from cessation of services to the next step in his or her life.

Discharging from Case Management services will occur when one or more of the following conditions are met:

- The Client no longer meets any of the criteria for Case Management services
- Client transfers to another location or service provider. If a client transfers to another location, agency, or service provider, (including a non-HIV/AIDS case manager), a discharge summary will be provided on request. If a client moves to another area, the case manager will make a referral for case management services in the new location
- The case manager is unable to locate or contact the Client within designated time frames, the Client will be closed

A discharge summary must be placed in each Client's file within 30 days of discharge. This summary shall include:

- Client's name
- Date services began
- Special client needs
- Services needed/actions taken
- Date of discharge
- Reason for discharge
- Referrals made at time of discharge

A written discharge notice which simply indicates the fact of discharge, not a summary, may be forwarded to external service providers, with whom the agency has been authorized by the Client to share information, within 30 days of the discharge.

Other Professional Services

Other Professional Services (PCN 16-02) allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities.

Allowable Costs Include

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
    - Living wills Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
        - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney

        - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
    - Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Unallowable Costs Include

- Criminal defense or class-action suits unrelated to access to services eligible for funding under the Ryan White Program

Subrecipient Requirements

- All legal counsel services must be performed by trained professional staff. Attorneys must have current licensure and hold certification through the Boards and Commissions and Bar Association in the State of South Carolina
- Paralegal staff or other employees must be qualified to hold the position in which they are employed. Non-licensed staff must be supervised by a licensed attorney
- Orientation to the target population and the HIV service delivery system in the State of South Carolina. Training should include but not limited to:
    - Available HIV/AIDS services in the region and the state;
    - How to access such services, especially Ryan White Part B funded services;
    - Ryan White Service Standards (Universal and Service Category Standards)
- Other professional must the certified to perform the Service required. For tax preparation, the individual should be a licensed Certified Public Accountant, a Tax attorney, or a Register tax return preparer with an IRS Tax Preparer certificate
- Maintain Documentation of:
    - Professional contract or personnel files/resumes/applications for employment reflect requisite experience and education. Supervisory records are kept on file
    - Professional contract file or personnel file reflects completion of orientation and signed job description
    - Orientation curriculum on file at provider agency

Outreach Services

Outreach Services (PCN-1602) principal purpose is identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities:

- Identification of people who do not know their HIV status and/or
- Linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options

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

Outreach Services Must:

- Use data to target populations and places that have a high probability of reaching PLWH who:
    - have never been tested and are undiagnosed,
    - have been tested, diagnosed as HIV positive, but have not received their test results, or
    - have been tested, know their HIV positive status, but are not in medical care;
- Be conducted at times and in places where there is a high probability that PLWH will be identified; and
- Be delivered in coordination with local and State HIV prevention outreach programs to avoid

duplication of effort

Allowable Costs Include

- Planning and delivering the coordination of local HIV prevention outreach programs to avoid duplication of effort
- Target population known through local epidemiologic data to be at disproportionate risk for HIV infection
- Target communities or local establishments that are frequented by individuals exhibiting high-risk behavior
- Provided quantified program reporting of activities and results to accommodate local evaluation of effectiveness

Unallowable Costs Include

- For HIV counseling and testing
- To support broad-scope awareness activities that target the general public rather than specific populations and/or communities with high rates of HIV infection
- To duplicate HIV prevention outreach efforts

Subrecipient Requirements

- Outreach staff must complete HIV prevention and care related trainings that is outlined in the Outreach binder. Training certificates/records should be kept for all appropriate staff
- Initial problems or needs should be identified and prioritized by the Client and the non-medical case manager. Document in client charts the assessment of needs
- Maintain Documentation of:
    - The design, implementation, target areas and populations, and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
    - Provide financial and program data demonstrating that no outreach funds are being used:
        - To pay for HIV counseling and testing
        - To support broad scope awareness activities
        - To duplicate HIV prevention outreach efforts
    - Outreach services are designed to identify individuals who know their status and are not in care and help them enter or re-enter HIV related medical care
    - Outreach services are planned and delivered in coordination with local HIV prevention outreach programs and avoid duplication of effort
        - Outreach activities and results can be quantified for program reporting and evaluation of effectiveness
            - Staff will follow-up on referrals to determine whether the contacts accessed medical care
            - Linkage to services
            - HIV+ attendance at first medical care appointment
            - HIV- referral for risk reduction
    - Discharge plan and summary in Client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable

Transition and Discharge: Client transitions when Outreach Services are no longer needed, goals have been met, upon death or due to safety issues.

Prior to transition: Reasons for transition and options for other service provision should be discussed with Client. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with Client via phone. If verbal contact is not possible, a certified letter must be sent to Client's last known address. If Client is not present to sign for the letter, it must be returned to the provider.

Documentation: Client's record must include:

- Date services began
- Special client needs
- Services needed/actions taken, if applicable
- Date of transition
- Reason(s) for transition/discharge
- Referrals made at time of transition/discharge, if applicable

Transfer: If client transfers to another location, agency, or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If Client moves to another area, transferring agency will make referral for needed services in the new location.

Unable to Locate: If Client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the Client's last known mailing address within five business days after the last attempt to notify the Client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made.

Withdrawal from Service: If client reports that services are no longer needed or decides to no longer participate in the Service Plan, Client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood or identify factors interfering with the Client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies.

Administrative Discharge: Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by the leadership according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the Client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the Client's chart.

Case Closure Protocol:

Case will be closed if Client:

- Has met the service goals
- Decides to transfer to another agency
- Needs are more appropriately addressed in other programs
- Moves out of State
- Fails to provide updated documentation of eligibility status thus, no longer eligible for services
- Can no longer be located
- Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan
- Exhibits pattern of abuse as defined by agency's policy

- Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison, or inpatient program
- Is deceased

Outreach Rounds:

- Contact Round 1
    - All cell on file
    - All home
    - All other
    - All work
- Wait 5 days
- Contact Round 2 (Alternative time)
    - All cell on file
    - All home
    - All other
    - All work
- Wait 5 days
- Contact Round 3
    - Emergency contact
    - Household member(s) who are aware of Client's HIV status
    - Text or Email if Client and Agency authorize
    - Letter if ok to send mail
    - Collateral with MCM/Housing CM/Pharmacy
    - Call all new number at 2 different times (am/pm)
- Wait 10 days
- Contact Round 4 (Queued for Field Visit)
    - Update returned mail
    - Database search
    - Print Outreach Summary you can take in the field (PE).
- Round 5
    - Field visit attempts
- Round 6
    - Follow up after made contact, but Client has not returned to care
- Round 7
    - Referral to Date to Care

Psychosocial Support Services

Psychosocial Support Services (PCN 16-02) provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns.

Allowable Costs Include

- Support and counseling activities
- Child abuse and neglect counseling
- HIV support groups
- Pastoral care/counseling
    - Available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation
- Caregiver support

- Bereavement counseling
- Nutrition counseling provided by a nonregistered dietitian
- Peer Services

Unallowable Costs Include

- Nutritional supplements (See ***Food Bank/Home Delivered Meals***)
- Social/recreational activities
- Client's gym membership

Subrecipient Requirements

- Pastoral care/counseling must be provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider)
- Pastoral care/counseling must be provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available
- Maintain documentation of:
    - Types and level of activities provided
    - Client eligibility
    - Funds are used only for allowable services
    - No funds are used for provision of nutritional supplements
    - Any pastoral care/counseling services meet all stated requirements

Referral for Health Care and Supportive Services

Referral for Health Care and Support Services (PCN 16-02) directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA RWHAP-eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services, or health insurance Marketplace plans).

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

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

Allowable Costs Include

- Include benefits/ entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services Referrals may be made:
    - Within the Non-medical Case Management system by professional case managers
    - Informally through community health workers or support staff
    - As part of an outreach program

Subrecipient Requirements

- Direct a client to a service in person or through other types of communication
- To provide benefits/entitlements counseling and referral consistent with HRSA requirements

- To manage such activities where these services are not provided as a part of Ambulatory/ Outpatient Medical Care or Case Management services
- Method of client contact/communication
- Method of providing referrals (within the Nonmedical Case Management system, informally, or as part of an outreach program)
- Referrals and follow up provided
- Maintain Documentation of:
    - Number and types of referrals provided
    - Benefits counseling and referral activities
    - Number of clients served
    - Follow up provided
    - Date of Service
    - Type of communication
    - Type of referral
    - Benefits counseling/referral provided
    - Follow up provided

Rehabilitation Services

Rehabilitation Services (PCN 16-02) provide HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Allowable Costs Include

- Physical, occupational, speech, and vocational therapy

Unallowable Costs Include

- Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable

Subrecipient Requirements

- Intended to improve or maintain a client's quality of life and optimal capacity for self-care
- Limited to allowable activities, including physical and occupational therapy, speech pathology services, and low-vision training
- Provided by a licensed or authorized professional
- Provided in accordance with an individualized plan of care that includes components specified by the grantee
- Maintain Documentation of:
    - Types of services provided
    - Type of facility
    - Provider licensing
    - An individualized plan of care
    - Types of rehabilitation services provided (physical and occupational therapy, speech pathology, low-vision training)
    - Dates, duration, and location of services

Assessment

- Provider will complete a comprehensive assessment within five (5) business days of the referral to include:

- Presenting issue
- Physical examination and evaluation performed by the therapist relevant to the type of therapy prescribed
- Diagnosis
- Prognosis

Care Plan

- In collaboration with the Client a plan of care will be developed within ten (10) business days of the completed comprehensive assessment.
  - The plan of care should be signed and dated by the Client and located in the Client's primary record. A copy of the plan will be offered to the Client and documented in the Client's record.
  - The plan of care should include:
    - Objective for rehabilitative services
    - Estimated number of sessions
    - Type of therapy
    - Estimated duration
  - Documentation that plan of care is being followed will include date therapy received, therapy performed, and progress toward meeting objectives in the Client's primary record
  - Plan of care must be reviewed not less than every six (6) months to determine if progress is being met towards meeting objective with documentation in the Client's primary record

Referral

- If the needs of the Client are beyond the scope of the services provided by the agency/provider, an appropriate referral to another level of care is made.
  - Documentation of referral and outcome of the referral is present in the Client's primary record

Discharge

- The agency and Client will collaborate on a discharge plan once objectives have been met.
  - Reasons for discharge may include:
    - Services are no longer needed
    - Services needed are outside the scope of rehabilitative services
    - Client is deceased
    - Client has moved out of the area

Substance Abuse Treatment Services – Residential

Substance Abuse Services (residential) (PCN 16-02) are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder.

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

Allowable Costs Include

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals

- Relapse prevention
- Acupuncture therapy*
- Detoxification, if offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Unallowable Costs Include

- Inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license

Subrecipient Requirements

- Services are provided by or under the supervision of a physician or by other qualified personnel with appropriate and valid licensure and certification as required by the state in which services are provided
- Services provided meet the service category definition
- Services are provided in accordance with a written treatment plan
- Assurance that services are provided only in a short-term residential setting
- Maintain Documentation of:
    - Provider licensure or certifications as required by the state in which Service is provided;
    - Provide assurance that all services are provided in a short-term residential setting
    - Maintain program files that document:
        - All services provided are allowable under this service category
        - The quantity, frequency, and modality of treatment services
    - Maintain client records (*Provide Enterprise)* that document:
        - The date treatment begins and ends
        - Individual treatment plan
        - Evidence of regular monitoring and assessment of client progress

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