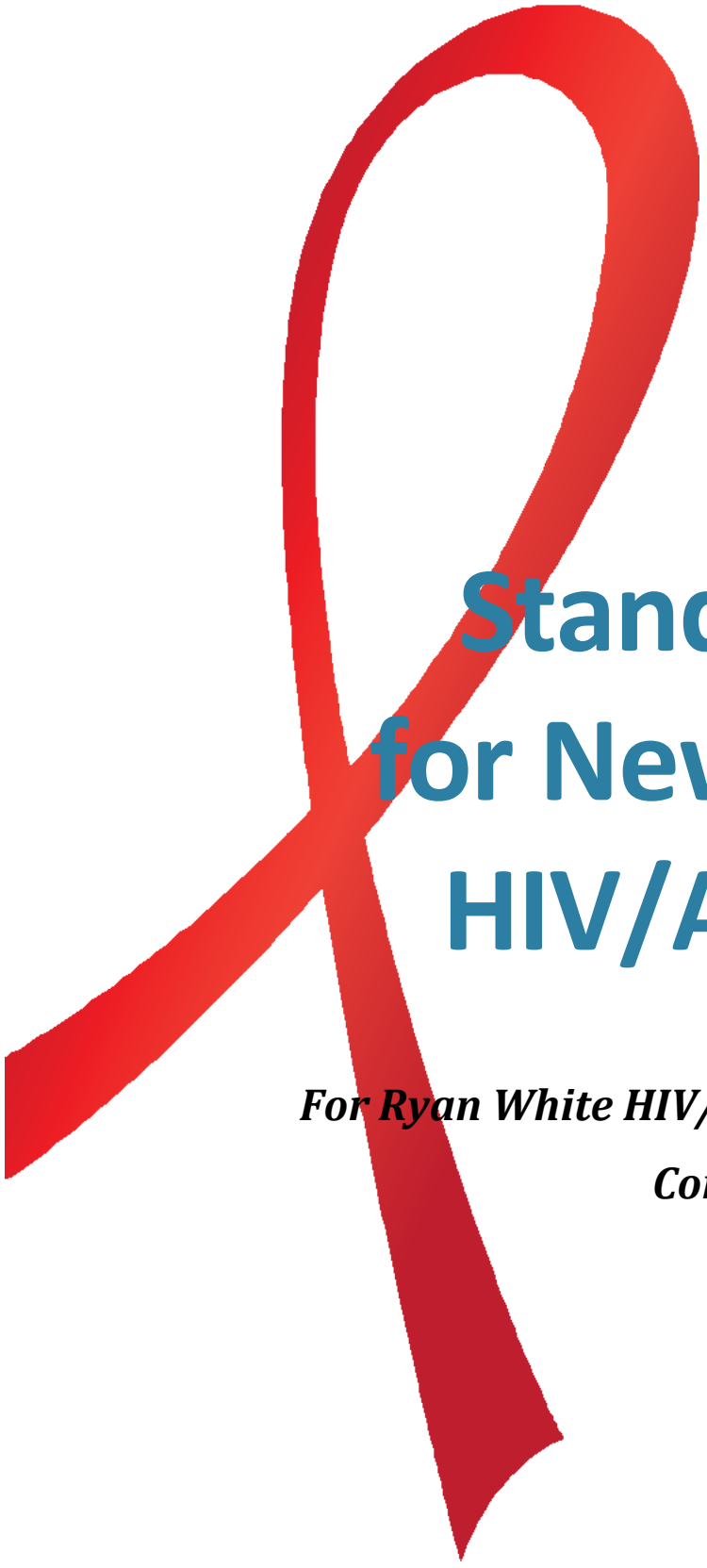

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Standards of Care for New Hampshire HIV/AIDS Services

For Ryan White HIV/AIDS Program (RWHAP) Part B

Core Medical and Support Services

Revised October 2020

Table of Contents

Introduction

The Standards of Care in this document were developed by the New Hampshire (NH) Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), NH Ryan White CARE Program for HIV/AIDS services funded through contracted providers using federal Ryan White Part B funds. The Standards of Care developed by the Boston Public Health Commission and the Massachusetts Department of Public Health and resources from NASTAD's Service Standards for Ryan White HIV/AIDS Program (RWHAP) Part B Programs document were utilized in the development of the NH Standards of Care for HIV/AIDS Services. Service Standards are reviewed annually and are updated in collaboration with the HIV Planning Group (HPG), Medical Advisory Board (MAB), and recipients to reflect the most current nationally recognized guidelines in HIV care and treatment and local NH requirements. The Standards of Care are publicly accessible and can be accessed online or by contacting the NH CARE Program. The full list of services covered by these standards is provided below.

Section I of the Standards of Care applies to all funded programs and is known as the Universal Standards of Care. Each heading begins with the objectives of the specific group of standards, and is followed by specific standards and measures.

In addition to these Universal Standards, Section II contains standards that apply to each specific service category for which the NH CARE Program contracts to providers in the community. These Service-Specific Standards of Care apply to components of service delivery that vary by service category. Providers of these services must comply with the Universal Standards of Care in Section I, as well as the Service-Specific Standards of Care in Section II.

Core Medical Services:

AIDS Drug Assistance Program (ADAP) Treatments
Early Intervention Services (EIS)
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
Home and Community-Based Health Services
Home Health Care
Medical Case Management Services
Medical Nutrition Therapy
Mental Health Services
Oral Health Care
Outpatient/Ambulatory Health Services
Substance Abuse Outpatient Care (Substance Use Disorder Care)

Support Services:

Food Bank/Home Delivered Meals
Housing
Linguistic Services
Medical Transportation
Non-Medical Case Management Services
Other Professional Services

Section I: Universal Service Standards of Care

IMPORTANT: Prior to reading these standards, please read the HRSA/HAB National Monitoring Standards--Universal.

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by Ryan White Part B and/or NH state funds (through NH Department of Health and Human Services). The Standards of Care establish the minimum standards intended to help agencies meet the needs of their clients. Providers may exceed these standards.

The objectives of the Universal Service Standards are to help achieve the goals of each service type by ensuring that programs:

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

1.0 – Intake, Eligibility, and Recertification

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

- assess client's immediate needs;
- inform the client of the services available and what the client can expect upon enrollment;
- review the client's eligibility for services, as determined by the NH CARE Program;
- establish whether the client wishes to enroll in a range of services or is interested only in a discrete service offered by the service provider;
- explain the agency policies and procedures inclusive of client's right to confidentiality and privacy;
- explain client's right to file a grievance;
- collect required state/federal client data for reporting purposes;
- collect basic client information to facilitate client identification and client follow up; and
- begin to establish a trusting client relationship.

All clients who request or are referred to HIV services will participate in the intake process. Intake is conducted by an appropriately trained program staff or intake worker. The intake worker will review client rights and responsibilities, explain the program and services to the client, explain the agency's confidentiality and grievance policies to the client, assess the client's immediate service needs, and secure permission from the client to release information (if there is an immediate need to release information).

Intake is considered complete if the following have been accomplished: (1) documentation of enrollment in the NH CARE Program; (2) and the information below (at a minimum) has been obtained from the client:

- name, address, social security number, phone, and email (if available);
- date of birth, sex at birth, gender identity, preferred pronouns, race, ethnicity;
- preferred method and language of communication (e.g., phone, email, or mail);
- preferred method of correspondence and emergency contact information;
- enrollment in other HIV/AIDS services including case management and other HIV/AIDS or social services; and
- primary reasons and need for seeking services at agency, inclusive of source of referral & date of first contact.

A client who chooses to enroll in services and who is eligible will be assigned a staff member who is responsible for making contact with the client to set up a time for a more thorough assessment, if necessary, to determine appropriate services. Referrals for other appropriate services will be made if ineligible. The intake process shall begin within 72 business hours of the first client contact with the agency. Ideally, the client intake process should be completed as quickly as possible; however, recognizing that clients may not have on hand the required documentation (e.g., documentation of enrollment in the NH CARE Program), the intake process should be completed within 30 days of beginning intake.

Intake, Eligibility, and Recertification Table

#	Standard	Measure
1.1	Clients must be eligible for Ryan White Part B services and must recertify every 6 months to continue receiving these services. Clients must apply through a case management agency or through their medical provider.	Documentation or proof of eligibility (ie. current CARE enrollment card) in client's file.
1.2	Clients are screened for eligibility for health insurance, other sources of reimbursement, and/or other benefits. Ryan White Part B is the payer of last resort.	Completed documentation of eligibility screening and/or other benefits in client's file.
1.3	Service provider has eligibility requirements for services, as applicable, and is reviewed yearly with staff.	Written policy on file at service provider; signed documentation of staff review on file.
1.4	An initial phone or in-person screening will be completed within 72 hours of referral or contact by the client including: • Current information, inclusive of date of birth • Scheduled date of first appointment • Source of referral & date of first contact by client • Documentation of language interpretation and/or other required accommodations for first visit	Documentation of initial intake in client file.
1.5	The intake process must be completed within 30 days of initial screening with client, unless otherwise specified within the Service-Specific Standards. A completed intake will include the following documentation: • Demographic information, inclusive of date of birth, sex at birth, gender identity, race, ethnicity, & primary/preferred language • Source of referral & date of first contact by client • Source of payment, inclusive of all forms of insurance and benefits • Scheduled date of first appointment • Assessment of immediate service needs	Completed intake, dated no more than 30 days after initial screening, in client's file.
1.6	For providers of services, client is asked about connection to case management. If client is not connected to case management, provider facilitates a referral to case management services.	Documentation of case manager and/or referral in client's file.

2.0 – Personnel and Volunteers

The objectives of the Standards of Care for personnel, inclusive of all staff, supervisors, individual adult volunteers, and students/interns are to:

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

All staff and program supervisors are provided and will sign a written job description with specific minimum requirements for their position. Individual adult volunteer and student/intern must receive and sign a written service agreement with specific task(s) for their volunteer support assignment. Agencies and providers are responsible for providing personnel with supervision and training to develop capacities needed for effective job and volunteer performance.

At a minimum, personnel should have the knowledge, skills, and ability to effectively fulfill their role and be able to provide appropriate care to clients living with HIV/AIDS, be able to complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). All personnel will receive consistent administrative supervision. In addition to administrative supervision, direct care staff will also receive consistent clinical supervision by a clinical supervisor.

Clinical Staff:

Clinical staff must be licensed or registered as required for applicable services they provide. Please refer to the Office of Professional Licensure and Certification at www.oplc.nh.gov for more information.

Administrative Supervision:

Administrative supervision includes topics related to staffing, policy, client documentation, reimbursement, scheduling, training, performance reviews, quality enhancement activities, and the overall operation of the service provider.

Clinical Supervision:

Clinical supervision include improving client care, ensuring client safety, and supporting direct care staff in their work with clients and their professional development.

Personnel Table

#	Standard	Measure
2.1	Personnel have the minimum qualifications expected for their job position, as well as other experience related to the position and the communities served.	Résumé in personnel file meeting the minimum requirements of the job description.
2.2	Personnel are credentialed if required to provide services.	Copy of current license or other documentation in personnel file.
2.3	Personnel know the requirements of their job description and the service elements of the program.	Documentation in personnel file that each staff member received job description. Must be signed and dated at or before start date.

2.4	Newly hired personnel are oriented within 6 weeks, and begin initial training within 3 months of being hired. Ongoing training continues throughout.	Signed documentation in personnel file of (a) completed orientation within 6 weeks of date of hire; (b) commencement of initial training within 3 months of date of hire; and (c) ongoing trainings.

3.0 – Transition, Discharge, and Case Closure

The objectives of the standards for Transition, Discharge, and Case Closure are to:

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

Agencies must assure written Client Discharge and Re-Entry into Care (after Discharge) Policies and Procedures are developed, and ensure staff is aware of the Policies and Procedures and follow them accordingly with proper documentation. Documentation should include grievance and service refusal policy requirements, when applicable, according to Universal Standard 3.2 and 4.4. Discharge and Reentry into Care procedures are to be determined by the agency.

If the client does not agree with the reason for discharge, the client should be referred to the provider agency's grievance and appeal procedure(s). Should a client be discharged from services, the client's case manager must be notified within 72 hours. If the case manager is unknown, the NH CARE Program must be notified within 72 hours.

Client transition, transfer, or discharge may fall into one of the following categories:

- Transfer
- Unable to locate
- Voluntary withdrawal from service
- Administrative discharge

A client must be transitioned and discharged from any service through a systematic process. Prior to discharge, reasons and options for other service provision should be discussed with the client. Whenever possible, this discussion should be face-to-face. If not possible, provider should attempt to talk with client via telephone.

Possible reasons for closing a case include:

- Meeting service goals and independently managing care;
- No longer meets eligibility criteria;
- Client requests a discharge;
- Client's needs change and/or would be better served through services at another service provider;
- Client action or behavior put the agency, service provider, or other clients at risk;

- Client sells or exchanges emergency assistance, food vouchers, or transportation vouchers for cash or other resources for which the assistance is not intended;
- Client moves/relocates out of the service area;
- Client is housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, State or Federal Correctional Facility or prison, or inpatient program;
- Client is deceased; and/or
- The agency is unable to reach a client, after three unsuccessful attempts 30 days after a formal notification communication has been dated (see *Unable to Locate*).

The process of transition, discharge, or case closure includes formally notifying clients of pending case closure and completing a discharge summary to be documented in the client record.

Discharge/Case Closure Documentation

When appropriate, case closure summaries will include a plan for client's continued success and ongoing resources to be utilized. 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. Agencies should maintain a list of resources available for the client for referral purposes.

Regardless of reason for transition/discharge, a **discharge summary** must be included in the client record with the following at minimum:

- Date and signature of case manager
- Date of engagement or retention activities
- Efforts made to engage or retain
- Progress made towards service plan
- Status of primary health care and support service utilization
- Action taken to overcome barriers
- Reasons for transition/case closure and criteria for re-entry into services
- Criteria for re-entry into services

Client Discharge Notification

- Voluntary Withdrawal: If client reports that services are no longer needed or decides not to participate in the service, the client may withdraw from services at any time.

- Transfer/Care Transition: A client may transfer to a different agency due to changing service needs or relocation. If the client transfers to a new agency or service provider, the transferring agency will provide the discharge summary and other requested files within five business days of request, and a warm handoff if appropriate. If the client relocates to another area, the transferring agency will make referral for needed services in the new location.

- 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 this reason must be provided written notification of and the reason for the discharge, and must be notified of possible alternative resources including the agency's grievance and appeal procedure(s).

- Unable to Locate: If a client cannot be located, the agency will document a minimum of three (3) unsuccessful attempts on three (3) separate dates (by the client preferred method of communication) over a 90 day period following the initial attempt. For clients accepting mail or email, notification must be mailed to the client's last known address within five (5) business days after the last attempt to notify the client. The letter will state the client is discharged from services within 30 days from the date of the letter if a follow up appointment with the provider is not scheduled.

  All attempts to contact the patient and notifications about case closure is documented in the client record and include the reason for transition/discharge. If a client fails to respond to a less intensive outreach method (email) a more intensive method (such as a telephone call) should be attempted.

Transition, Discharge, and Case Closure Table

#	Standard	Measure
3.1	Agency has a transition, discharge, and case closure procedure in place implemented for clients for any of the reasons listed in the narrative above.	Documentation of transition, discharge, and case closure procedures on file at provider agency
3.2	Grievance procedure exists and reviewed yearly with staff.	Written procedure on file at provider agency; signed documentation of staff review on file.
3.3	Agency provides appropriate resources for transition and discharge.	Completed transition and discharge summary on file, signed by client (if possible) and supervisor. Summary should include: • a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.
3.4	Agency makes appropriate attempts to notify client of reason(s) for discharge and/or case closure according to narrative above.	Completed discharge and/or case closure summary on file, signed by client (if possible) and supervisor. Summary should include: • reason for discharge and/or case closure; • dates and modalities for attempts to reach client; and • a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency.

3.5	Agency has a due process policy in place for involuntary discharge of clients from services; policy includes a series of verbal and written warnings before final notice and discharge.	Due process policy on file as part of transition and discharge procedure. Due process policy described in the Client Rights and Responsibilities document (see Universal Standard 4.4).
3.6	Agency has a process for maintaining communication with clients who are active and identifying those who are inactive.	Documentation of agency process for maintaining communication with active clients and identifying inactive clients.
3.7	Agency provides clients with referral information to other services, as appropriate.	Resource directories or other material on HIV related services are on file and provided to clients.

4.0 – Client Rights and Responsibilities

The objectives of establishing minimum standards for Client Rights and Responsibilities are to:

- ensure that services are available to all eligible clients;
- ensure that services are accessible for clients;
- involve consumers of HIV/AIDS services in the design and evaluation of services; and
- inform clients of their rights and responsibilities as consumers of HIV/AIDS services.

HIV/AIDS services funded by NH DPHS must be available to all clients who meet eligibility requirements and must be easily accessible.

A key component of HIV/AIDS service delivery is the historic and continued involvement of consumers in the design and evaluation of services. Substantive client input and feedback must be incorporated into the design and evaluation of HIV/AIDS services funded by NH DPHS. This can be accomplished through a range of mechanisms including consumer advisory boards, participation of consumers in HIV program committees or other planning bodies, and/or other methods that collect information from consumers to help guide and evaluate service delivery (e.g., needs assessments, focus groups, or satisfaction surveys).

The quality of care and quality of life for people living with HIV/AIDS is optimal when consumers are active participants in their own health care and share in health care decisions with their providers. This can be facilitated by ensuring that clients are aware of and understand their rights and responsibilities as consumers of HIV/AIDS services. Providers of HIV/AIDS services funded by NH DPHS must provide all clients with a Client Rights and Responsibilities document that includes, at a minimum, the agency's confidentiality policy, the agency's expectations of the client, the client's right to file a grievance, the client's right to receive no-cost interpreter services, and the reasons for which a client may be discharged from services, including a due process for involuntary discharge. "Due process" refers to an established, step-by-step process for notifying and warning a client about unacceptable or inappropriate behaviors or actions and allowing the client to respond before discharging them from services. Some behaviors may result in immediate discharge.

Clients are entitled to access their files with some exceptions: agencies are not required to release psychotherapy notes, and if there is information in the file that could adversely affect the client (as determined by a clinician) the agency may withhold that information but should make a summary available to the client. Agencies must provide clients with their policy for file access. The policy must at a minimum address how the client should request a copy of the file (in writing or in person), the

time frame for providing a copy of the file (cannot be longer than 30 days), and what information, if any, can be withheld.

Client Rights and Responsibilities Table

#	Standard	Measure
4.1	Services are available to any individual who meets program eligibility requirements.	NH CARE Program enrollment and eligibility information on file.
4.2	Services are accessible to clients.	Site visit conducted by funder that includes, but is not limited to, review of hours of operation, location, proximity to transportation, and other accessibility factors.
4.3	Agency complies with Americans with Disabilities Act (ADA) criteria for programmatic accessibility. In the case of programs with multiple sites offering identical services, at least one of the sites is in compliance with relevant ADA criteria. https://www.ada.gov/pubs/adastatute08.htm	Site visit conducted by funder.
4.4	Program provides each client the following information: • the agency's client confidentiality policy, including disclosure to the client of the agency's responsibility of mandated reporting; • the agency's expectations of the client as a consumer of services; • the client's right to file a grievance; • the client's right to receive no-cost interpreter services; • the reasons for which a client may be discharged from services, including a due process for involuntary discharge.	Documentation in client file that required information has been given to client.
4.5	Clients have the right to access their file.	Copy of agency's Client File Access policy is signed by client and kept in client file.

5.0 – Client Grievance Process

The objectives of the standards for Client Grievance Process are to:

- provide a fair process to address clients' grievances; and
- facilitate communication and service delivery.

All provider agencies offering services must have a written policy that addresses a grievance procedure. Grievance procedures must be posted in areas frequently visited by clients.

A provider agency grievance procedure ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a

policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the client may appeal the decision if the client's grievance is not settled to his/her/their satisfaction within the provider agency.

Client Grievance Process Table

#	Standard	Measure
5.1	Grievance procedure exists and is reviewed yearly with staff.	Written procedure on file at provider agency; signed documentation of staff review on file.
5.2	Grievance procedure is posted in areas frequently visited by clients (e.g., waiting room, exam room)	Grievance policy is visible in locations frequented by clients.
5.3	Grievance procedure is signed and dated by the client	Acknowledgement of grievance procedure in client's file

6.0 – Cultural and Linguistic Competence

The objective for establishing standards for Cultural and Linguistic Competence is to provide culturally and linguistically appropriate services to everyone we serve.

Culture is the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, and values of individuals and groups, all which may be influenced by race, ethnicity, religion, class, age, gender, gender identity, disability, sexual orientation, and other aspects of life upon which people construct their identities. In our work with people living with HIV/AIDS, culture may also include past or current substance use, homelessness, mental health, and/or incarceration, among others.

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together as a system, agency, or among individuals that enables effective delivery of services. Cultural competence is a goal toward which all providers must aspire, and a destination that is never completely achieved. Thus, all providers should be involved in a continual process of learning, personal growth, experience, reflection, education, and training that increases knowledge, skills, and awareness of one's own biases and enhances the ability to provide culturally competent services to all individuals living with HIV/AIDS.

Linguistic competence is the ability to communicate effectively with all clients, including individuals who require language and communication assistance to access services from providers. This includes individuals who are deaf or hard of hearing, blind or have low vision, have speech challenges, have limited English proficiency (LEP), and/or who have low literacy skills. Requirements for language and communication access derive from federal civil rights laws, federal guidance, and state laws.

Culturally and linguistically appropriate services are services that:

- respect, relate, and respond to a client's culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the

culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- are based on individualized assessment and stated client preferences rather than assumptions based on perceived or actual membership in any group or class.

As part of the on-going process of building cultural and linguistic competence, providers should strive to develop:

- a comfort with and appreciation of cultural and linguistic difference;
- interpersonal behaviors that demonstrate and convey concern and respect for all cultures;
- the comfort and ability to acknowledge the limits of personal cultural and linguistic competence and the skills to elicit, learn from, and respond constructively to relevant personal and cultural issues during service interactions; and
- a commitment to increasing personal knowledge about the impact of culture on health and specific knowledge about the communities being served.

Ongoing trainings that help build cultural and linguistic competence can include a range of topics that help build specific skills and knowledge to work and communicate more effectively with all the communities we serve.

There are resources available. The National CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care), from the U.S. Department of Health and Human Services, provide a framework for organizations to best serve the nation's increasingly diverse communities and offer specific steps for organizations to take to make their services more culturally and linguistically appropriate. The National CLAS Standards can be accessed at: https://thinkculturalhealth.hhs.gov/. NH specific related resources and additional information on the guidance for contractor/bidder federal civil rights laws compliance and culturally and linguistically appropriate services can be accessed at the DHHS Vendor Contract Exhibits and Forms page: https://www.dhhs.nh.gov/business/forms.htm.

Cultural and Linguistic Competence Table

#	Standard	Measure
6.1	Service provider complies with Federal Civil Rights Laws and Civil-Rights related previsions in the Departments contract documents, policies and procedures – found under Culturally and Linguistically Appropriate Services (CLAS) – Related Resources & Guidance (https://www.dhhs.nh.gov/business/forms.htm)	• Annual review of Contractor Training Video *Civil Rights-Related Provisions in DHHS Procurement Processes, RFP Language, and Contract Documents;* signed documentation of Agency review on file (https://mm.nh.gov/media/dhhs/contractor-training-omhra.m4v) • Federal Civil Rights Laws Compliance Checklist completed annually (https://www.dhhs.nh.gov/business/documents/fed-cr-checklist.pdf)

6.2	Service providers assess the cultural and linguistic needs, resources, and assets of its service area and population(s) served.	Service providers collect and use community demographic, epidemiologic, and service utilization data in service planning for population(s) served and to guide which languages must be prioritized for any translated material and signage in the organization.
6.3	Service providers understand and have in place procedures regarding federal civil rights laws compliance requirements to provide effective communication assistance to persons who need it to ensure meaningful access to their programs and/or services.	Submit detailed description of language assistance services to NH CARE Program within ten (10) days of the date the contract is approved by Governor and Council.
6.4	Family and friends are not considered adequate substitutes for qualified interpreters because of privacy, confidentiality, bias, and medical terminology competency issues. Use of a qualified interpreter assures the quality of the interaction of the service provider with the client. Clients' confidentiality concerns can often be addressed by using qualified interpreters from other geographic locations (such as by over-the-phone or video-remote interpreter services). Clients have the right to refuse a qualified interpreter and to have a family member or friend over the age of 18 interpret. Clients who choose to waive their right to a free, qualified interpreter must sign a written waiver that is explained to the client in the client's language by a qualified interpreter. Because the particular circumstances of any encounter vary over time, and the individual family member or friend may vary, therefore providers must obtain a waiver annually **or** any time the family member or friend that is providing interpretation has changed. The provider should still offer a free qualified interpreter regularly.	A Waiver of Interpreter Services form must be signed by the client (after being explained in the client's own language by a qualified interpreter). Any signed waivers should be maintained in the client file. Any signed waivers must be specific to particular circumstances or particular individuals (relative, friend, etc.). Waivers are only good for up to a year if the circumstances and the specific individuals remain constant. (https://www.dhhs.nh.gov/business/documents/sample-waiver.pdf)
6.6	Service providers recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community served.	Service providers must be able to describe efforts to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV/AIDS.
6.7	Programs' physical environment and facilities are welcoming and comfortable for the populations served.	Funder site visit.

6.8	Service providers have organizational strategies in place to enable individuals with Limited English Proficiency (LEP) and other communication access needs to file complaints and/or grievances with the organization – See Universal Standards 5.0.	Funder site visit.
6.9	Service providers conduct on-going assessments of the organizational, program and personnel (including volunteer and student/intern) cultural and linguistic competence.	Service providers integrate cultural competence measures into organizational, program and personnel assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

7.0 – Client Privacy and Confidentiality

The objectives of the standards for Client Privacy and Confidentiality are to:

- guarantee client confidentiality and ensure quality care;
- facilitate communication and service delivery; and
- ensure that agencies comply with appropriate state and federal regulations.

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

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, and use of services. Each agency will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a *Release of Information Form* describing under what circumstances client information can be released. Clients shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated and are considered no longer binding after one year. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

The Federal Child Abuse Prevention and Treatment Act requires each State to have provisions or procedures for requiring certain individuals to report known or suspected instances of child abuse and neglect (Federal: 42 U.S.C. § 5106a(b)(2)(B)(i)). NH Law requires any person who suspects that a child under age 18 has been abused or neglected must report that suspicion immediately to the NH Division of Children, Youth, and Families (New Hampshire RSA 169-C:29-31). Additionally, the Bureau of Elderly and Adult Services carries out the legal requirements of the Protective Services to Adults Law under the Adult Protection Program. This program serves to provide protection for incapacitated adults who are age 18 and older, who are abused, neglected, exploited, or self-neglecting. The Adult Protection Law requires any person who has a reason to believe that an incapacitated adult has been subjected to abuse, neglect, exploitation or self-neglect to make a report to the appropriate state agency or office (New Hampshire RSA 161-F: 42-57).

Service providers must also have a *File Review Consent Form* in which clients grant permission for NH DPHS to review client files on site during site visits. For clients who choose not to sign the client consent form, agencies must be able to code all unique identifying information in accordance with all federal, state, and local laws.

Client Privacy and Confidentiality Table

#	Standard	Measure
7.1	Service provider has a data security and confidentiality policy that is updated and reviewed by personnel yearly. Policy complies with the Bureau of Infectious Disease Control (BIDC) data security and confidentiality policy in accordance with the Oath to Maintain Security and Confidentiality for Contractors (Appendix A) and meets or exceeds all requirements of the Centers for Disease Control and Prevention (CDC) "Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculous Programs".	Yearly updated data security and confidentiality policy on file and meets all requirements of BIDC and CDC documents. Signed documentation of personnel review on file.
7.2	A complete file for each client exists. All client files are stored in a secure and confidential location, and electronic files are protected from unauthorized use, per specifications outlined in the Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculous Programs and BIDC Security & Confidentiality Policy in accordance with the Oath to Maintain Security and Confidentiality for Contractors (Appendix A).	Paper files stored in a locked file or cabinet with access limited to appropriate personnel. Electronic files are password protected with access limited to appropriate personnel. Paper copies of all required forms that must be signed by the client and/or provider in every client's file.
7.3	Incidents and breaches of information involving Protected Health Information (PHI) must be reported to the DHHS Privacy Officer and to the DHHS Security Officer immediately after the service provider becomes aware of any breaches of PHI and/or any security incident that may have an impact on PHI of the CARE Program. The service provider must complete a risk assessment within 48 hours of the breach and immediately report the findings of the risk in writing to DHHS in accordance with the service provider contract.	On-site review of any incidents and breaches of PHI to ensure appropriate notifications made to DHHS Privacy Officer and DHHS Security Officer, including findings of the risk assessment. DHHS Privacy Officer: DHHSPrivacyOfficer@dhhs.nh.gov DHHS Security Officer. DHHSInformationSecurityOffice@dhhs.nh.gov
7.4	Service provider must have a policy on consent for release of information and the policy must align with State and Federal laws in accordance with the Service provided. Policy must be is updated and reviewed by personnel yearly.	Yearly updated consent for release of information policy on file and meets State and Federal requirements in accordance with the service provided. Signed documentation of personnel review on file.
7.5	Client's consent for release of information is determined. Release of information must include the following: • Name of Client • DOB of Client • Name of agency/individual with whom information will be shared	An up-to-date *Release of Information Form* exists for each specific request for information and each request is signed and dated by the client. Each release form indicates the destination of the client's information or from whom information is being requested before the client signs the release.

	• Information to be shared • Duration of the release consent • Client signature	
7.6	Client's consent for on-site file review by funders is determined.	Signed and dated *File Review Consent Form* in client's file. Consent forms have an expiration date of one year. In event of refusal of consent, file is coded to remove identifying information in accordance with federal, state, and local laws.
7.7	Personnel complete training on NH mandatory reporting laws within 3 months of hire.	Certificate of training in personnel file.

8.0 – Operational Requirements

The objectives of the standards for Operational Requirements are to:

- ensure client and personnel safety and well-being;
- ensure ongoing efforts to avoid fraud, waste and abuse; and
- ensure that agencies comply with appropriate state and federal regulations.

All provider agencies offering services must have a written policy and procedure manual that is inclusive of policies and procedures listed in the sections above. In addition, the manual must include policies on crisis management, universal precautions, and handling of medical emergencies. Lastly, the agency must comply with applicable state and federal workplace and safety laws and regulations, including fire safety.

Operational Requirements Table

#	Standard	Measure
8.1	Employee Code of Ethics exists that includes, at a minimum: • Conflict of interest • Prohibition on use of property, information, or position without approval or to advance personal interest • Fair dealing – engaged in fair and open competition • Confidentiality • Protection and use of company assets • Compliance with laws, rules, and regulations • Timely and truthful disclosure of significant accounting deficiencies • Timely and truthful disclosure of non-compliance	Written Employee Code of Ethics on file at provider agency; signed documentation of personnel review on file.
8.2	Anti-Kickback policy exists that addresses, at minimum, prohibition of employees from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, ordering,	Anti-Kickback policy on file at provider agency; signed documentation of personnel review on file.

	of any goods, facility services or items.	
8.3	Crisis management policy exists that addresses, at minimum, infection control (e.g., needle sticks), mental health crises, and dangerous behavior by clients or personnel. Personnel review crisis management policy yearly.	Written policy on file at provider agency; signed documentation of personnel review on file.
8.4	Policy on universal precautions exists; personnel are trained in universal precautions. Personnel review universal precautions yearly.	Written policy on file at provider agency; signed documentation of personnel review on file.
8.5	Policy and procedures exist for handling medical emergencies and is reviewed yearly with personnel.	Written policy on file at provider agency; signed documentation of personnel review on file.
8.6	Agency complies with all applicable state and federal workplace and safety laws and regulations, including fire safety.	Policy and procedures on file and posted in visible location at site; signed documentation of personnel review in personnel file.
8.7	Agency agrees to accept reimbursement rates at the current NH Medicaid rate as outlined in NH CARE Program contract Exhibit B, section 2 the contract as payment in full. The agency may not balance bill the client, or charge the client beyond that which has been billed to the CARE Program. Policy updated and reviewed yearly with administrative and finance personnel.	Written policy on file at provider agency; signed documentation of administrative and finance personnel review on file.
8.8	Service providers include input from consumers (and as appropriate, caregivers) in the design and evaluation of service delivery.	Documentation of meetings of consumer advisory board, or other mechanisms for involving consumers in service planning and evaluation (e.g., satisfaction surveys, needs assessments) in regular reports to funder(s).

Section II: Contracted Service-Specific Standards

In addition to the Universal Standards of Care, providers of services must also meet additional standards that are specific to services funded by the provider's contract with the NH CARE Program. This section contains standards of care specific to the following services:

- AIDS Drug Assistance Program (ADAP) Treatments
- Early Intervention Services
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Home and Community-Based Health Services
- Home Health Care
- Medical Case Management
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care (Substance Use Disorder Care)
- Foodbank/Home Delivered Meals
- Housing
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Other Professional Services

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

AIDS Drug Assistance Program (ADAP) Treatments

Description

According to Policy Clarification Notice 16-02, the AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under RWHAP Part B to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have no coverage or limited health care coverage. HRSA RWHAP ADAP formularies must include at least one FDA-approved medicine in each drug class of core antiretroviral medicines from the U.S. Department of Health and Human Services' Clinical Guidelines for the Treatment of HIV. HRSA RWHAP ADAPs can also provide access to medications by using program funds to purchase health care coverage and through medication cost sharing for eligible clients. HRSA RWHAP ADAPs must assess and compare the aggregate cost of paying for the health care coverage versus paying for the full cost of medications to ensure that purchasing health care coverage is cost effective in the aggregate. HRSA RWHAP ADAPs may use a limited amount of program funds for activities that enhance access to, adherence to, and monitoring of antiretroviral therapy with prior approval.

Program Guidance

NH ADAP provides this service to eligible clients by covering either the full cost of medications, or the cost of deductibles and co-pays for insurance policies. In New Hampshire, the "full cost" of medications is set equal to the price paid by NH Medicaid. Like NH Medicaid, NH ADAP is registered as a 340B entity under Section 602 of the Veterans Health Care Act of 1992, Title XXVI of the PHS Act. This allows NH ADAP to submit to manufacturers for rebates on medications it purchases.

NH ADAP is responsible for:

- Establishing ADAP eligibility within the legislative guidelines of the Ryan White CARE Act and HRSA/HAB policies and guidelines;
- Determining the type, amount, duration and scope of ADAP services;
- Ensuring each class of antiretroviral medication is represented on the formulary; and
- Securing the best price available for all products including 340B pricing or better

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	ADAP matches NH Medicaid's formulary of medications for the treatment of HIV disease and the prevention of opportunistic infections that contains FDA approved medications.	Documentation of: • A formulary that includes medications from each class of antiretrovirals in the PHS Clinical Practice Guidelines for the use of Antiretroviral Agents in HIV-1 infected Adults and Adolescents • Medications on the formulary are FDA approved
B.2	ADAP secures the best price available for all products including 340B pricing or better	Documentation of: • A process to secure the best price available for all products on the formulary including 340B pricing or better

B.3	Data sharing agreement in place with Centers for Medicare and Medicaid (CMS) for the purpose of tracking true out of pocket costs (TrOOP) for ADAP clients with Medicare Part D for whom ADAP is paying Medicare Part D premiums, co-pays, and deductibles	Documentation of: • Signed data sharing agreement between ADAP and CMS • Development and implementation of data systems necessary to track and account for ADAP payments for TrOOP costs (system may be with the ADAP Pharmacy Benefit Manager)

Personnel

See Universal Standards 2.0 – Personnel

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Early Intervention Services (EIS)

Description

According to Policy Clarification Notice 16-02, EIS for Part B must be provided as defined in the RWHAP legislation § 2651(e) of the Public Health Service Act. The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service.

Program Guidance

Funds awarded under this service category may be used to support early detection of HIV, to help prevent or delay the onset of AIDS. EIS must include the following four components:

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

Please refer to https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm for Early Intervention Services sub recipient adherence to Center for Disease Control and Prevention routing HIV guidelines. Agencies receiving NH EIS funds are responsible for:

- Helping clients who are unaware of their HIV status learn their status and receive either a referral to prevention services or referral and linkage to HIV care services;
- Creating linkage agreements (Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA)) and making referrals;
- Working with key points of entry to create connections between services;
- Providing referral to additional services to meet immediate needs inclusive of primary care, medical case management, entry into substance use disorder treatment, and/or treatment adherence counseling;
- Providing education on the HIV service delivery system, HIV disease progression and managing life with HIV disease, and working with clinicians to meet client goals.

Intake, Eligibility, and Recertification

#	Standard	Measure
A.1	Client is eligible for EIS services. To be eligible, applicants must meet one or more of the following: • Be unaware of their HIV status • Identify as having a high risk of HIV transmission, including: • Persons who identify a history of incarceration;	Completed documentation of eligibility in client's file.

	• Persons who identify as having sex or shares injection drug use equipment with an HIV-positive partner; • Persons having more than one sex partner since last HIV test; • Persons who inject drugs and shares needles or works with others; • Persons who exchange sex for drugs or money; • Persons who have been treated for another sexually transmitted disease; • Persons who have been diagnosed with or treated for hepatitis or tuberculosis; or • Persons who have had sex with someone who identifies with any of above or someone whose sexual history is unknown	

Key Services Components and Activities

Targeted HIV Testing and Counseling

#	Standard	Measure
B.1	Targeted HIV testing and counseling policy must be in place. Clients must identify as having a high risk of HIV transmission, including: • Men who have sex with men; • Women who identify as Black and/or Hispanic; • Persons who identify a history of incarceration; • Persons who identify as having sex or shares injection drug use equipment with an HIV-positive partner; • Persons having more than one sex partner since last HIV test; • Persons who inject drugs and shared needles or works with others; • Persons who exchange sex for drugs or money • Persons who have been treated for another sexually transmitted disease; • Persons who have been diagnosed with or treated for hepatitis or tuberculosis; or • Persons who have had sex with someone who identifies with any of	Copy of policy made available. Documentation of risk category in client file.

	above or someone whose sexual history is unknown	
B.2	Clients who test negative for HIV will receive the test results in-person or via phone within 5 business days of testing date. If unable to reach a client after 3 attempts, results can be mailed.	Date(s) of attempts to contact client are recorded in client file. Date results given recorded in client file, including who provided (or mailed) the results and the method of delivery.
B.3	Clients who test positive for HIV will receive their test results in-person within 3 business days. If client demonstrates hardship in returning to clinic to receive results, results may be given via phone. If unable to reach a client after 3 attempts, clinic will call the NH Division of Public Health's Infectious Disease Prevention, Investigation and Care Services Section, Care Engagement Program for assistance. Positive results are never mailed.	Date(s) of attempts to contact client are recorded in client file. Date results given (or contact with the Care Engagement Program) is recorded in client file, including who provided the results and the method of delivery.
B.4	Provide HIV testing utilizing 4th generation HIV testing technology for those individuals who meet the criteria of a recent exposure to HIV and rapid HIV testing technology for all others.	Recent exposure date, type of test performed and date of testing in client file.
B.5	Obtain consent for HIV testing from individual.	Consent in client file.
B.6	Submit specimens within 72 hours of specimen collection to the NH Department of Public Health Laboratories for testing and detection of HIV.	Specimen submission recorded in client file.
B.7	All preliminary positive test results must be called into the NH Division of Public Health's Infectious Disease Prevention, Investigation and Care Services Section, no later than 4:00pm the following business day after the day of testing.	Call must be recorded in client file with day and time call placed.

Referral Services

#	Standard	Measure
C.1	Linkage agreements in place for outpatient/ambulatory health services and HIV prevention services.	Copies of MOUs or MOAs are made available.
C.2	Referrals are documented in client file.	Date and place of referral is documented in client's file.

Linkage to Care

#	Standard	Measure
D.1	Clients who have been newly diagnosed with HIV are educated on the State notification process, including the role Partner Services.	Completed education session documented in client's file.

D.2	Clients who have been newly diagnosed with HIV are referred to an infectious disease provider.	Referral date, provider, and date of initial lab work is documented in the client file.
D.3	Clients who have been newly diagnosed with HIV are referred to case management, substance use disorder treatment, and other core medical services as indicated.	Referral date and provider are documented in client file.
D.4	HIV negative clients are referred to HIV prevention, pre-exposure prophylaxis (PrEP) programs, and other services as indicated.	Referral date and provider are documented in client file.
D.5	Service providers shall have a protocol outlining the process used when referring clients to any services.	Copy of protocol made available.
D.6	Core service providers shall have a protocol outlining the process used for clients who are newly diagnosed with HIV. Protocol must include referral to the medical provider, follow up to ensure client attended first appointment, and it was completed.	Copy of protocol made available.

Outreach Services and Health Education/Risk Reduction Services

#	Standard	Measure
E.1	Conduct an individual assessment of client's knowledge of HIV risk and transmission, disease progression and health care delivery system.	Completed assessment filed in client's file.
E.2	Based on results of the assessment, provide Outreach and Health Education/Risk Reduction education on areas that will support both HIV positive and negative clients to meet their health goals.	Health education sessions are documented in the client file.

Personnel

In addition to Universal Standards 2.0 – Personnel, personnel must complete approved training for the operation of the rapid test technology being utilized, data collection, and counseling and referral services.

#	Standard	Measure
F.1	Personnel complete training on all rapid test technology being utilized.	Certificate of training in personnel file.
F.2	Personnel complete data collection training.	Certificate of trainings in personnel file.
F.3	Personnel complete counseling and referral services training.	Certificate of trainings in personnel file.

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description

According to Policy Clarification Notice 16-02, Health Insurance Premium and Cost Sharing Assistance 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 coverage program. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying cost sharing on behalf of the client.

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

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

Program Guidance

By statute, RWHAP funds may not be used "for any item or service to the extent that payment has been made, or can reasonably be expected to be made…" by another payment source. This means grantees must assure that funded providers make reasonable efforts to secure non-RWHAP funds whenever possible for services to individual clients. Grantees and their contractors are expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance) to extend finite RWHAP grant resources to new clients and/or needed services.

RWHAP funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments to assist eligible low-income clients in maintaining health insurance or receiving medical benefits under a health insurance or benefits program, including high risk pools. However, RWHAP funds may not be used to pay for any administrative costs outside of the premium payment of the health plans or risk pools.

The overall objectives of this service category are to:

- Pay for insurance plans that are licensed by the State of NH to cover essential health benefits as defined by the Affordable Care Act;
- Ensure that clients are enrolled expeditiously and maintain coverage without interruption while the Program pays for their premiums;
- Ensure that the Ryan White CARE program pays only for those plans that contribute a cost savings to the Program in the aggregate; and

- To reduce the financial burden associated with medical care and increase continuity of health insurance coverage and pharmacy benefits.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

NH CARE Program & Subrecipients

Subrecipients must accurately assess clients for the health insurance benefits offered by the plan. The core service provider must collect all of the pertinent insurance information from the client. Plan information collected must include a plan description, including levels of drug coverage, levels of deductibles and copayments, maximum annual out-of-pocket amounts, and provider network availability.

#	Standard	Measure
B.1	For all insured clients, health insurance plan information is collected.	Collect all of the pertinent insurance information from the client and document it in the CAREWare system.
B.2	Prior to the binding payment for health insurance, health insurance plan information must be provided and include a plan description, including levels of drug coverage, levels of deductibles, co-insurance, and copayments, maximum annual out-of-pocket amounts, and provider network availability. Client insurance coverage to be reimbursed represents a savings to the NH CARE Program.	Assess clients accurately for the health insurance benefits offered by the plan. The cost of paying for the health care coverage (including all other sources of premium and cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services.
B.3	Refunds or payments by the insurance company to the policyholder must be signed over to or reimbursed to the CARE Program.	Provide mechanism through which clients are aware of this policy and can submit refunds or payments to the CARE Program.
B.4	Payments cannot be made directly to the client by the CARE Program to reimburse for any payments previously made by the client.	Provide mechanism through which payment can be made on behalf of the client.
B.5	Purchase of ACA Marketplace insurance may enable the client to receive Advance Premium Tax Credits (APTC) based on the client's estimated income. If, because of a change in income over the tax year, the CARE Program overpays the insurance premiums, the client must reimburse any excess premium received by the IRS in the form of a refund, to the CARE Program. If the Program underpaid the premium, it may pay the IRS on behalf of the client for excess taxes paid by the client, resulting from the change in income.	Policy on file stating responsibility of CARE Program to vigorously pursue the reconciliation of any tax credits.

Insurance Benefit Manager

The Insurance Benefit Management core service provider will operate a process for making payments

to health insurance carriers for premiums and healthcare providers for copays, coinsurance, and deductibles. Payment information collected must include premium amount paid, deductibles and copayments made, maximum annual out-of-pocket amounts reached. Dates of invoices and payments must be recorded in a monthly statement of accounts.

#	Standard	Measure
B.1	Collect all invoices and other documentation from clients, insurance companies, and healthcare providers for all payments made on behalf of NH CARE Program clients.	Completed payments for insurance coverage and copayments/deductibles in client's file.
B.2	Process insurance premium payments on behalf of eligible NH CARE Program clients, including but not limited to: private insurance, Medicare Supplementary, Medicare Part D plans, and COBRA plans.	On-time payments for premium payments documented in client's file.
B.3	Collect and adjudicate insurance copayments and deductible claims for outpatient visits, lab tests, and procedures.	On-time payments for copayments/deductibles documented in client's file.

Personnel

See Universal Standards 2.0 – Personnel

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Home and Community-Based Health Services

Description

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

Allowable Activities Include:

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

Program Guidance

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

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the New Hampshire Ryan White CARE Program Service Standards as outlined here.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Home and Community-Based Health Service services are documented in a client file. Files must contain: • Type, dates, and location of services • Initial and subsequent assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service

B.2	Provision of the following services as indicated: • Appropriate mental health, developmental, and rehabilitation services • Day treatment or other partial hospitalization services • Home health aide services and personal care services in the home • Durable medical equipment	Documentation that: • Care is provided by professionals certified in their jurisdictions to provide services in the home and community-based setting • Only allowable services are provided • Services are provided based on a written care plan signed by a case manager and a clinical health care professional responsible for the individual's HIV care and indicating the need for these services • The care plan specifies the types of services needed and the quantity and duration of services

Personnel

In addition to Universal Standards 2.0 – Personnel, Home and Community-Based Health Services must provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
C.1	Home and Community-Based Health Services is provided by professionals licensed/certified by appropriate state and/or federal agencies as indicated	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
C.2	Home and Community-Based Health Service licensed/certified professionals are required to complete 4 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment and Service Plan

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
A.1	An initial comprehensive assessment is performed on the client by the appropriate provider in alignment with the referral, including reason for the service	Documentation of comprehensive assessment in client's file signed and dated by the provider
A.2	A reassessment is performed on the client by the appropriate provider at the frequency established in the treatment plan, not to exceed six months	Documentation of reassessment in client's file signed and dated by the provider
A.3	A comprehensive medical history will be taken at least once a year and at a minimum must include: • New Symptoms • Medications (all) • Knowledge of HIV regimen • HIV transmission risk behaviors and	Documentation of a comprehensive medical history that is signed and dated by the provider

	risk reduction methods • Sexual history • Behavioral Health • Alcohol and recreational drug use • Tobacco use • Allergies • Pain • Social supports • Housing • Insurance • Intimate partner violence	
A.5	A treatment plan must be updated after each assessment. At a minimum, it must include: • Current treatments and other interventions as indicated • Date and signature of professional who provided the service	Documentation of a treatment plan that is signed and dated by the provider
A.6	A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client, including recommendations as to the appropriate level of care • Planning for continuity of care, including assistance making the transition from one care setting to another • Collaborative approaches to health, including frequency of medical visits	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
A.7	Clients not following up with Home and Community-Based Health Services in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management or patient navigator services is documented in the client file and is signed and dated.
A.8	All referrals for HIV specialty care and/or other Part B services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Medical Case Management

Description

According to Policy Clarification Notice 16-02, Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

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

Allowable Activities Include:

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

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

Program Guidance

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

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

Key Services Components and Activities

Clients enroll in the NH CARE Program through a contracted Medical Case Management agency. Applicants must be a NH resident, are an individual living with HIV, and have a gross household income at 500% or less than the Federal Poverty Limit (FPL). Enrollment documents are provided by the client to the NH CARE Program Enrollment Coordinator via CAREWare. Re-enrollments are required every 6 months. Clients are only eligible for assistance from the NH CARE Program, while they are enrolled; services received outside of enrollment or during an enrollment lapse are the responsibility of the

client. Required enrollment documents include proof of HIV status, income, residency, and an annual application to NH Medicaid (for those at or below 200% FPL). The NH CARE Program will enroll an infant born to an HIV-positive mother and pay for prophylaxis treatment, whether or not the mother is a client of the NH CARE Program.

The objective of this service category is to improve health outcomes through comprehensive, individualized care focused on linkage to HIV medical care, current HIV health status, HIV medication adherence, mental health, substance use, HIV knowledge & understanding, health literacy, sexual health, dental, and self-efficacy.

Intake, Eligibility, and Recertification

#	Standard	Measure
A.1	Client is eligible for Ryan White Part B services. To be eligible, applicants must: • Be living with HIV • Apply through a case management agency or through their medical provider • Provide a signed and dated release of information • Provide proof of residency in New Hampshire • Have a household income at or below 500% of the Federal Poverty Level • Provide proof of income • Provide proof of insurance coverage, if any • Complete an annual Medicaid application if household income is below 200% of the Federal Poverty Level Client must recertify for Ryan White Part B services every 6 months, up to 30 days prior to their current enrollment end date. To recertify, applicants must: • Recertify through a case management agency or through their medical provider • Provide proof of income, changes in insurance coverage, or any changes in residency • Complete an annual Medicaid application if household income is below 200% of the Federal Poverty Level	Completed documentation of eligibility in client's file.

A.2	A client awaiting a confirmatory HIV result to confirm a new HIV diagnosis is eligible for Ryan White Part B services. To be eligible, applicants must: • Provide an attestation from healthcare personnel or partner services personnel of presumptive HIV status, which may be indicated if the person is identified as a partner of a person living with HIV and/or the person had a rapid positive test • Apply through a Medical Case Management agency or through their medical provider • Provide a signed and dated release of information • Provide self-attestation of residency in New Hampshire • Have a household income at or below 500% of the Federal Poverty Level • Provide self-attestation of income • A full application must be received within 30 days of the release of information signature date	Completed documentation of eligibility in client's file.
A.3	Case managers will meet with newly diagnosed clients or clients who have fallen out of care (e.g. do not have access to medications and/or have not had a medical visit with an HIV provider within the past 12 months), within two business days of client's request, to complete the initial assessment of service needs.	Date of client requested appointment and the date of the first initial appointment filed in client file.
A.4	Case managers will meet with clients requesting medical case management services (e.g., have moved to NH and was in care in previous state, clients new to the program and are in care with access to medications) within 10 business days of client's request, to complete the initial assessment of service needs.	Date of client requested appointment and the date of the first initial appointment filed in client file.
A.5	Case managers will contact client 30 days prior to enrollment end date, if client has not scheduled an appointment. If case manager does not hear from the client after two weeks, the case manager will reach out to client by an alternate method of contact, if possible. During the week prior to expiration, the case manager shall make one last attempt to reach the client.	Documentation of attempted contacts in client file.

Personnel

In addition to Universal Standards 2.0 – Personnel, Medical Case Management must provide clients with the highest quality services through appropriately trained and experienced staff including both medically credentialed and other staff who are part of the clinical care team. The objectives of personnel standards for Medical Case Management are to:

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

HIV medical case managers partner with clients and/or caregivers, develop supportive relationships, and assist clients to progress toward care plan goals. At a minimum, all medical case managers hired by provider agencies will be able to demonstrate the ability to provide client-centered care, coordinate a multidisciplinary care team, evaluate care and service utilization, facilitate referrals, and provide assistance with healthcare navigation for clients, in addition to documentation as required by their position, and previous experience in the human service delivery field.

All HIV case managers and case manager supervisors will be given a written job description that outlines specific minimum qualifications. All HIV case managers will complete the NH Case Manager Curriculum as outlined by the NH CARE Program within 3 months of date of hire.

#	Standard	Measure

B.1	Newly hired HIV Medical Case Managers must meet a minimum of one of the following criteria:
	• A licensed health or social service professional; or
	• An individual under the direct supervision of licensed health or social service professional, and experience in the HIV field, or in the medical or human services-related field, such as: nursing, social work, psychology, counseling, or health education in accordance with the following guidance:
	  • Bachelor's degree with one (1) year experience; or
	  • Associate's degree with two (2) years of experience; or
	  • High school diploma or GED with two (2) years of experience.
		Job description on file that describes minimum qualifications of standard.
		
		Résumé or documentation in personnel file meeting minimum requirements of the job description

B.2	Newly hired HIV medical case managers have at least the following qualifications: • the ability to coordinate services, information, and referrals for clients in need of HIV related medical and support services; • the ability to complete documentation required by the case management position; and • experience and/or education consistent with the job description.	Job description on file that describes minimum qualifications of standard. Résumé in personnel file meeting minimum requirements of the job description.
B.3	Newly hired or promoted HIV case manager supervisors have at least the minimum qualifications described above for case managers plus five years of case management experience.	Résumé in personnel file meeting minimum requirements of standard.
B.4	Newly hired case managers will complete the Case Manager Curriculum as outlined by the NH CARE Program within 3 months of date of hire.	Signed documentation of completed training on file.
B.5	Personnel receive at least one hour of administrative supervision per month. For staff not credentialed as a licensed professional, at least one hour of clinical supervision per month is required. Administrative and clinical supervision is conducted by separate individuals.	Signed documentation on file indicating the date of supervision, type of supervision (administrative or clinical), and name of supervisor.
B.6	Case managers (1.0 FTE) have a minimum of twenty-five (25) active clients and a maximum of fifty (50) active clients.	Files exist for at least twenty-five (25) active clients for each 1.0 FTE case manager. Written justification for any caseload size of less than twenty-five (25) clients per 1.0 FTE case manager must be on file at the agency. Written justification for any caseload size of more than fifty (50) clients per 1.0 FTE case manager must be on file at the agency.

Assessment and Service Plan

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

A Case Management Assessment Form has been provided by the NH CARE Program. Agencies may use their own form, but assessments must address at minimum the following components:

- Basic information about the client;
- Linkage to HIV medical care;
- Current HIV health status;
- HIV medication adherence;
- Mental health;
- Substance use;
- HIV knowledge & understanding;
- Health literacy;
- Sexual health;
- Dental; and
- Self-efficacy / Activities of daily living (ADL).

Agencies may use their own electronic medical record system, or reasonable facsimile, but must enter specified data into CAREWare as directed by the NH CARE program.

Based on the information collected during the intake and initial assessment, the case manager will create a customized Individual Service Plan (ISP) with the client. The ISP serves as the road map for the client's progress through the HIV service system and will include measureable goals and objectives that encourage client self-sufficiency. The ISP should include specific services needed and referrals to be made including timeframes and a plan for follow-up. The ISP should address harm reduction and positive prevention, if the assessment indicates a need in these areas ISP must be completed within 30 days of the initial intake date and must be reviewed and approved by the case management clinical supervisor.

Assessment and service planning are ongoing processes. It is the responsibility of the case manager to reassess and document a client's needs and his/her ISP as needed but no less than once every six (6) months.

#	Standard	Measure
C.1	Comprehensive initial assessment is completed within 30 days of intake, to assess service needs in the following areas: • Basic information about the client; • Linkage to HIV medical care; • Current HIV health status, inclusive of review of most recent viral load and CD4 lab results; • HIV medication adherence; • Mental health; • Substance use; • HIV knowledge & understanding; • Health literacy; • Sexual health; • Dental; and • Self-efficacy / Activities of daily living (ADL).	Completed case management assessment form in the client file.

C.2	Individual service plan (ISP) is completed collaboratively with the client within 30 days of intake and includes short-term and long-term goals, action steps to address each goal, specific services needed and referrals to be made, barriers and challenges, a timeline, and a plan for follow- up.	In addition to having the client's and case manager's signature, a completed ISP is reviewed, approved, and signed by the case management clinical supervisor and stored in client's file.
C.3	Reassessment of client needs is completed as needed, but not less than once every six months. At least once per year, re-assessment must be conducted face-to-face.	Documentation of reassessment in client's file, including whether the re-assessment was conducted over the phone or face-to- face.
C.4	Case managers will continuously monitor client progress to assess the efficacy of the ISP. Case managers will re-evaluate the ISP at least every 6 months with adaptations as necessary. At least once per year, re-assessment must be conducted face-to-face.	Documentation of client progress towards goals developed in service plan, including whether the re-assessment was conducted over the phone or face-to- face.
C.6	Case managers will provide timely and coordinated access to medically appropriate levels of health and support services to ensure continuity of care.	Documentation of supported referrals to appropriate medical and support services documented in client file including, date supported referral offered and client acceptance or denial of referral.
C.7	Case management supervisor conducts a quality assurance file review at least quarterly following the six month assessment/reassessment to ensure that client files meet standards.	Documentation in client's file or separate location (e.g., binder).
C.8	For staff not credentialed as a licensed professional, licensed clinician will meet with case managers and sign off on service plan within 30 days of service plan development.	Documentation of signature in client file.
C.9	Each agency will have a documented clinical supervision procedure for staff not credentialed. At the minimum, it should include the frequency and the information that will be reviewed during clinical supervision.	Written procedure on file at provider agency; signed documentation of clinical supervision review on file.

Transition, Discharge, and Case Closure

In addition to Universal Standards 3.0 – Transition, Discharge, and Case Closure, the objective of the transition, discharge, and case closure standards are to ensure staff support a smooth transition for clients.

#	Standard	Measure
D.2	Case managers will support clients who inform them that they will move out of state or jurisdiction, or who will become over income for services by the NH CARE Program, in identifying additional resources.	Documentation of support of transition planning in client file.

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Medical Nutrition Therapy

Description

According to Policy Clarification Notice 16-02, Medical Nutrition Therapy includes:

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

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

Program Guidance

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

The overall objectives of the Medical Nutrition Therapy Service Category are to:

- assess and respond appropriately to the physical, nutritional, dietary, and therapeutic needs of clients; and
- ensure that clients have adequate knowledge of nutritional needs and awareness of strategies to accomplish nutritional goals.

Intake, Eligibility, and Recertification

In addition to Universal Standards 1.0 – Intake, Eligibility, and Recertification

#	Standard	Measure
A.1	Supplements are provided to those who are unable to eat solid food or require additional nutrition.	Clients receiving nutritional supplements have documentation of eligibility to receive supplements in their files.

Key Services Components and Activities

#	Standard	Measure
B.1	Medical Nutrition Therapy services are documented in a client file. Files must also contain: • Types, dates, and location of services • Initial and subsequent nutrition evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up	Client files document services that are dated and signed by the by professional who provided the service

	• Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	
B.2	Provision of the following services as indicated: • Nutrition assessment and screening • Dietary/nutritional evaluation • Food and/or nutritional supplements per provider's recommendation • Nutrition education and/or counseling • All services must be pursuant to a health care professional's referral	Documentation in client file of completed: • Initial nutritional assessment • Nutritional assessment updated at minimum every six months • Documentation of educational counseling • Provision of supplements, if indicated • Services are provided based on a written care plan signed by a health care professional responsible for the individual's HIV care and indicating the need for these services • The care plan specifies the types of services needed and the quantity and duration of services

Personnel

In addition to Universal Standards 2.0 – Personnel, Medical Nutrition Therapy must provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
C.1	Medical Nutrition Therapy is provided by a professional licensed as a Registered Dietician in NH	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
C.2	Medical Nutrition Therapy licensed professionals are required to complete 4 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment and Service Plan

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
D.1	An initial comprehensive nutritional assessment is performed on the client by the appropriate provider in alignment with the referral including: • Changes in health • Goals of nutrition therapy • Medical considerations (both HIV and others); • How medical nutrition therapy might address medication side effects; • Food allergies/intolerances; • Interactions between medicines,	Documentation of nutritional assessment in client's file signed and dated by the provider.

	foods, and complimentary therapies; • Dietary restrictions; • Physician's order for medical nutrition therapy; • Assessment of nutrition intake vs. estimated need; • Food preferences and cultural components of food; • Macro nutritional, micro nutritional and dietary supplements; • Food preparation capacity (appliances, abilities, utensils, etc.); • Actual height and weight, pre-illness usual weight, weight trends, goal weight, ideal weight, and percent ideal weight; • Body mass index (BMI); and • Lean body mass and fat	
D.2	A treatment plan must be updated after each assessment. At a minimum, it must include: • Medical information • Laboratory and biochemical data • Current diet • Calculated intake compared to nutrient needs • Weight • Anthropometric measurements and history • Relevant psychosocial data • Current treatments and other interventions as indicated including frequency of services, planned number of sessions, and types and amounts of nutritional supplements • Date and signature of professional who provided the service	Documentation of a treatment plan that is signed and dated by the provider
D.3	A reassessment is performed on the client by the appropriate provider at the frequency established in the treatment plan, not to exceed six months	Documentation of reassessment in client's file signed and dated by the provider
D.4	A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client, including recommendations as to the appropriate level of care	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider

	• Planning for continuity of care, including assistance making the transition from one care setting to another • Collaborative approaches to health, including frequency of medical visits	
D.5	Clients not following up with Medical Nutrition Therapy in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management services or patient navigator services is documented in the client file and is signed and dated.
D.6	All referrals for HIV specialty care and/or other services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Mental Health Services

Description

According to Policy Clarification Notice 16-02, Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients 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.

Program Guidance

Mental Health Services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

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

- have policies in place to protect clients' rights;
- provide services with licensed (or authorized within the state) professionals who have appropriate education and experience; and
- assess and respond appropriately to the routine and emergency psychological and psychosocial needs of clients.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Mental Health services are documented in a client file. Files must contain: • Types, dates, and location of services • Initial and subsequent mental health evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service

B.2	Provision of the following services as indicated: • Outpatient psychological and psychiatric screening; • Assessment; • Diagnosis; • Treatment; and • Counseling services	Documentation in client file of completed: • Initial mental health assessment • Mental health assessment updated in accordance with the treatment plan • Treatment plan completed and updated accordingly • The care plan specifies the types of services needed and the quantity and duration of services
B.3	Individuals have sufficient information about the service to provide informed consent for mental health services	Client file includes signed and dated consent form. Therapeutic disclosure will be reviewed and signed by all participants and must be compliant with NH Mental Health statutes. At a minimum, the disclosure must include: • therapist's name; • degrees, credentials, certifications, and licenses; • business address, business phone; • relevant licensing board description and contact information; • treatment methods and techniques; • potential risks and benefits of treatment; • options for second opinion and an option to terminate therapy at any time; • statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to NH Board of Mental Health Practice; • information about confidentiality and the legal limitations of confidentiality; and • space for the participant and therapist's signature and date.
B.4	Mental health services should be relevant to the client's current situation.	Treatment plan signed and dated by mental health provider and client in client file.
B.5	Clients will receive services that are evidence-based and suited to the client's diagnosed condition.	Progress notes signed and dated by mental health provider detailing interventions in client file.
B.6	Mental health services should be comprehensive and should address the unique needs of people living with HIV.	Progress notes signed and dated by mental health provider in client file.

Personnel

In addition to Universal Standards 2.0 – Personnel, Mental Health must provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
C.1	Staff members are licensed or authorized within the state, as necessary, to provide mental health services in NH.	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
C.2	Mental Health licensed or authorized professionals are required to complete 4 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment and Service Plan

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
D.1	An initial comprehensive mental health assessment is performed with the client by the appropriate provider including at a minimum biological, psychological, and social history	Documentation of mental health assessment in client's file signed and dated by the provider including: • Statement of client's presenting problem; • Psychiatric or mental health treatment history; • Family, relationships and support systems; • Client strengths; • 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; and • Diagnostic Statistical Manual (DSM) V diagnosis
D.2	Client assessments will be conducted within 7 days of client's first visit with a substance use disorder professional. All assessments must be documented in client's file within 24 hours of the assessment and must contain the clinician's signature and date.	Documentation of completed intake, signed assessment, and progress notes in client's file within specified timeframe.
D.3	A treatment plan must be updated after each assessment and developed collaboratively with the client. The client is offered a copy of the treatment plan. At a minimum, it must include: • Statement of problem; • Prioritized goals and objectives individualized to the client; • Interventions and modalities; • Established timeframes for reevaluation; • Referrals, inclusive of resources that	Documentation of a treatment plan that is signed and dated by the provider in client's file. When possible, documentation of a treatment plan that is signed and dated by the client must be in client's file. If no client signature and date by the client, explanation must be in client's file.

	may benefit the client, including recommendations as to the appropriate level of care; • Planning for continuity of care, including assistance making the transition from one care setting to another; • Projected treatment end date; • Any recommendations for follow up; and • The signature of the mental health professional rendering services.	
D.4	A written plan for crisis management must be updated after each assessment and developed collaboratively with the client. The client is offered a copy of the plan. At a minimum, it must include: • Signs of behavioral health crisis; • Supports available; and • Coping skills.	Documentation of a treatment plan that is signed and dated by the provider in client's file. When possible, documentation of a treatment plan that is signed and dated by the client must be in client's file. If no client signature and date by the client, explanation must be in client's file.
D.5	A reassessment is performed with the client by the appropriate provider at the frequency established in the treatment plan, not to exceed one year	Documentation of reassessment in client's file signed and dated by the provider
D.6	Clients not following up with Mental Health services in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management services or patient navigator services is documented in the client file and is signed and dated.
D.7	All referrals for HIV specialty care and/or other services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Oral Health Care

Description

According to Policy Clarification Notice 16-02, Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and certified dental assistants.

Program Guidance

Oral Health Care services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

The overall objectives of the Oral Health Care Standards of Care are to:

- provide access to treatment by licensed dental health care professionals;
- appropriately address issues of consent and confidentiality for a client enrolled in services; and
- deliver high quality services corresponding to a client's level of need.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Oral Health services are documented in a client file. Files must contain: • Types, dates, and location of services • Initial and subsequent oral health evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the professional who provided the service
B.2	Provision of the following services as indicated: • Outpatient diagnostic, preventative, and therapeutic services	Documentation in client file of completed: • Initial oral health care assessment • Oral health care assessment updated in accordance with the treatment plan • Treatment plan completed and updated accordingly • The care plan specifies the types of services needed and the quantity and duration of services

B.3	Individuals have sufficient information about the service to provide informed consent for oral health care services	Client file includes signed and dated consent form.
B.4	Oral health care services should be relevant to the client's current situation.	Treatment plan signed and dated by oral health care provider and client in client file.
B.5	Clients will receive services that are evidence-based and informed by the American Dental Association Dental Practice Parameters	Progress notes signed and dated by oral health care provider detailing interventions in client file.
B.6	Oral health care services should be comprehensive and should address the unique needs of people living with HIV.	Progress notes signed and dated by oral health care provider in client file.

Personnel

In addition to Universal Standards 2.0 – Personnel, Oral Health Care must provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
C.1	Staff members are licensed or authorized within the state, as necessary, to provide oral health care services in NH	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
C.2	Oral Health Care licensed or authorized professionals are required to complete 4 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment and Service Plan

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
D.1	An initial comprehensive oral health care assessment is performed with the client by the appropriate provider and is to include: • Overview of medical history; • Physical examination of teeth, gums, and mouth; and • X-rays and/or panoramic radiographs For clients needing emergency dental services, a future comprehensive oral health care assessment must be scheduled within 3 months if not provided.	Documentation of comprehensive oral health care assessment in client's file signed and dated by the provider. For emergency services only, a scheduled day and time for a comprehensive oral health care assessment is recorded in client's file within 3 months of the emergency service if not previously provided.

D.2	A client must receive a periodontal screening once per year to include: • Assessment of medical and dental histories (evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer evaluation); • Quantity and quality of attached gingival; • Bleeding; • Tooth mobility; and • Radiological review of the status of the periodontium and dental implants.	Documentation of periodontal screening in client's file signed and dated by the provider.
D.2	A treatment plan must be updated after each assessment and developed collaboratively with the client. At a minimum, it must include as clinically indicated: • Preventative care; • Maintenance and elimination of oral pathology; • Periodontal treatment plan; • Elimination of caries; • Replacement or maintenance of tooth space or function; • Provision of pain relief; • Consultation or referral for conditions where treatment is beyond the scope of services offered; • Visit frequency; and • The signature of the oral health care professional rendering services.	Documentation of a treatment plan that is signed and dated by the provider in client's file
D.3	A reassessment is performed with the client by the appropriate provider at the frequency established in the treatment plan, not to exceed six months.	Documentation of reassessment in client's file signed and dated by the provider
D.4	Oral health education must be provided and documented as clinically indicated. At a minimum, it must include: • Oral hygiene instructions (daily brushing and flossing; daily use of fluorides) • Smoking/tobacco cessation counseling	Documentation oral health education in client's file signed and dated by the provider
D.5	Clients not following up with Oral Health Care services in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management or patient navigator services is documented in the client file and is signed and dated.

D.6	All referrals for HIV specialty care and/or other services are documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Outpatient/Ambulatory Health Services

Description

According to Policy Clarification Notice 16-02, Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed health care provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, and using telehealth technology for HIV-related visits.

Allowable Activities Include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventative care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance

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

Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the New Hampshire Ryan White CARE Program Service Standards as outlined here.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
A.1	Outpatient/Ambulatory Health Service services are documented in a client medical file. Files must contain: • Date of HIV diagnosis • Initial and subsequent health assessments, inclusive of medical	Client files document services that are dated and signed by the provider

	history and comprehensive physical examination • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be signed and dated	
A.2	Provision of the following services, as indicated: • Diagnostic testing, including laboratory testing • Early intervention and risk assessment • Preventative care and screening, including immunizations • Physical examination • Medical history taking • Reproductive and sexual health assessment • Diagnosis, treatment and management of physical and behavioral health conditions • Behavioral risk assessment, subsequent counseling, and referral • Prescription and management of medication therapy • Access to antiretroviral therapies, including combination antiretroviral treatment, and prophylaxis and treatment of opportunistic infections • Treatment adherence • Education and counseling on health and prevention issues • Pediatric developmental assessment and well-baby care • Referral to and provision of HIV-related specialty care related to HIV diagnosis	Documentation that: • Services are provided as part of the treatment of HIV infection • Services are consistent with HHS Guidelines • Service is not being provided by an emergency room or inpatient facility • Laboratory tests are ordered by a licensed/certified provider that are consistent with medical and laboratory standards
A.3	Provider has policies and procedures to address the needs of incapacitated clients, including policies addressing advance directives and treatment and care decisions	Written policies on file

A.4	Provider has written information accessible to individuals concerning their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives such as the Health Care Proxy or Durable Power of Attorney for Health Care	Written policy on file
A.5	Provider provides education to staff and clients about advance directives (NH Hospital Association – Advance Care Planning Guide)	Written educational materials and resources made available to clients and staff, including referral information to legal advocacy Services

Personnel Qualifications

Provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
A.1	Outpatient/Ambulatory Health Services is provided by health care professionals licensed/certified by appropriate state and/or federal agencies	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
A.2	Outpatient/Ambulatory Health Service licensed/certified providers are required to complete 10 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment & Service Plan

Services rendered are consistent with Health and Human Service guidelines.

#	Standard	Measure
A.1	An initial comprehensive medical history and physical assessment is performed on the client by the outpatient medical care provider no more than 30 days after initial screening is made	Documentation of comprehensive medical history and physical assessment in client's file signed and dated by the provider
A.2	A comprehensive medical history and physical reassessment is performed on the client by the outpatient medical care provider at the frequency established in the client care plan, not to exceed one year	Documentation of comprehensive medical history and physical reassessment in client's file signed and dated by the provider
A.3	A comprehensive medical history will be taken at least once a year and at a minimum must include: • New Symptoms • Medications (all) • HIV medication adherence screening • Adherence to medications and clinical care visits • Knowledge of HIV regimen • Reproductive and sexual health considerations	Documentation of a comprehensive medical history that is signed and dated by the provider

	• HIV transmission risk behaviors and risk reduction methods • Sexual history • Behavioral Health • Alcohol and recreational drug use • Tobacco use • Allergies • Pain • Social supports • Housing • Insurance • Intimate partner violence	
A.4	A comprehensive physical exam must be completed at least once a year and at a minimum must include: • Vital signs • Weight • General appearance and body habitus, inclusive of evaluation for lipodystrophy • Skin • Oropharynx • Lymph nodes • Heart and lungs • Abdomen • Neurologic • Psychiatric (e.g. mood, affect, and attention) • Vision and funducopic examination (if CD4 <100cells/µL • Ears/Nose • Genitorectal examination • Testicular examination • Prostate examination • Breast examination • Women: pelvic examination; cervical Pap test; consider anorectal examination, anal Pap test • Men: consider anal examination, anal Pap test	Documentation of a comprehensive physical exam that is signed and dated by the provider
A.5	A treatment plan must be completed at least once a year. At a minimum, it must include: • Current antiretroviral treatment and other medications as indicated • Screening and vaccination recommendations / history	Documentation of a treatment plan that is signed and dated by the provider
A.6	A care plan must be completed at least once a year in collaboration with the client. The client is offered a copy of the care plan. At a minimum, it must include: • Prioritized goals individualized to the	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider

	client • Established timeframes for reevaluation • Resources that may benefit the client, including recommendations as to the appropriate level of care • Planning for continuity of care, including assistance making the transition from one care setting to another • Collaborative approaches to health, including frequency of medical visits	
A.7	Clients not following up with Outpatient/Ambulatory Health services in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management or patient navigator services is documented in the client file and is signed and dated.
A.8	All referrals for HIV specialty care and/or other Part B services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Substance Use Disorder Care
(HRSA Service Category: Substance Abuse Outpatient Care)

Description

According to Policy Clarification Notice 16-02, Substance Abuse Outpatient Care (henceforth referred to as Substance Use Disorder Care) is the provision of outpatient services for treatment of drug and/or alcohol use disorders. Activities under Substance Use Disorder Care service category include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance

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

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

Residential care and inpatient detoxification in a hospital setting are not allowable under this service category.

Substance Use Disorder Care services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

The overall objectives of the Substance Use Disorder Care services are to:

- comply with state regulations, including licensing requirements, for substance use disorder services such as the American Society of Addiction Medicine (ASAM) guidelines and Commission on Accreditation of Rehabilitation Facilities (CARF) certification;
- provide services that are supportive of people living with HIV; and
- provide services with skilled, licensed professionals with experience and/or education in relevant disciplines.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Substance use disorder services are documented in a client file. Files must also contain: • Types, dates, and location of services • Initial and subsequent substance use disorder evaluation and assessments • Individualized treatment plan and reassessment of treatment plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • Discharge plan, if indicated • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service
B.2	Provision of the following services as indicated: • Screening • Assessment • Diagnosis, and/or • Treatment of substance use disorder, including: o Pretreatment/recovery readiness programs o Harm reduction o Behavioral health counseling associated with substance use disorder o Outpatient drug-free treatment and counseling o Medication assisted therapy o Neuro-psychiatric pharmaceuticals o Relapse prevention	Documentation in client file of completed: • Initial substance use disorder assessment • Substance use disorder assessment updated in accordance with the treatment plan • Treatment plan completed and updated accordingly • Treatment plan specifies the types of services needed and the quantity and duration of services
B.3	Individuals have sufficient information about the service to provide informed consent for substance use disorder care services.	Client file includes signed and dated consent form. Therapeutic disclosure will be reviewed and signed. At a minimum, the disclosure must include: • therapist's name; • degrees, credentials, certifications, and licenses; • business address, business phone; • relevant licensing board description and contact information; • treatment methods and techniques; • potential risks and benefits of treatment; • options for second opinion and an option to terminate therapy at any time; • statement that in a professional relationship, sexual intimacy is never appropriate and should be reported to

		NH Board of Licensing for Alcohol and Other Drug Use Professionals; • information about confidentiality and the legal limitations of confidentiality; and • space for the participant and therapist's signature and date.
B.3	Clients will be placed in a level of substance use disorder (SUD) treatment consistent with placement criteria established by ASAM.	The client file demonstrates that the client's situation was analyzed in terms of ASAM criteria and that program placement is consistent with findings.
B.4	Clients will receive services that are evidence-based and suited to the client's diagnosed condition.	Progress notes signed and dated by mental health provider detailing interventions in client file.
B.5	Treatment approaches will be guided by biopsychosocial assessment and individualized treatment plans.	The client file contains a biopsychosocial assessment, treatment plan, and ongoing progress notes.
B.6	Substance use disorder services should be comprehensive and should address the unique needs of people living with HIV.	Progress notes signed and dated by substance use disorder provider in client file.

Personnel

In addition to Universal Standards 2.0 – Personnel, Substance Use Disorder Care must provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

#	Standard	Measure
C.1	Staff members are licensed or authorized within the state, as necessary, to provide substance use disorder services and have experience and skills appropriate to the specified substance use disorder treatment modality.	Current license(s) on file from appropriate state and/or federal agencies (e.g., clinic or Hospital license)
C.2	Substance use disorder licensed or authorized professionals are required to complete 4 hours of HIV/AIDS continuing education annually	Annual continuing education documented in personnel file

Assessment and Service Plan

Services rendered are consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines.

#	Standard	Measure
D.1	An initial comprehensive substance use disorder assessment is performed with the client by the appropriate provider	Documentation of substance use disorder assessment in client's file signed and dated by the provider including: • Substance use history; • Statement of client's presenting problem; • Psychiatric or mental health history and treatment; • Family, relationships and support systems; • Client strengths; • Cultural influences; • Education and employment history; • Legal history; • General and HIV related medical history; and • HIV risk behavior and harm reduction.
D.2	Client assessments will be conducted within 7 days of client's first visit with a substance use disorder professional. All assessments must be documented in client's file within 24 hours of the assessment and must contain the clinician's signature and date.	Documentation of completed intake, signed assessment, and progress notes in client's file within specified timeframe.
D.3	A treatment plan must be updated after each assessment and developed collaboratively with the client. The client is offered a copy of the treatment plan. At a minimum, it must include: • Statement of problem; • Prioritized goals and objectives individualized to the client; • Interventions and modalities; • Established timeframes for reevaluation; • Referrals, inclusive of resources that may benefit the client, including recommendations as to the appropriate level of care; • Planning for continuity of care, including assistance making the transition from one care setting to another; • Projected treatment end date; • Any recommendations for follow up; and • The signature of the substance use disorder professional or mental health professional rendering services.	Documentation of a treatment plan that is signed and dated by the provider in client's file. When possible, documentation of a treatment plan that is signed and dated by the client must be in client's file. If no client signature and date by the client, explanation must be in client's file.
D.4	A reassessment is performed with the client by the appropriate provider at the frequency established in the treatment plan, not to exceed one year	Documentation of reassessment in client's file signed and dated by the provider

D.5	Clients not following up with substance use disorder services in accordance with the care plan are referred to case management services or patient navigator services for re-engagement in care	Documentation of attempt to contact client is signed and dated in medical file. Referral to case management or patient navigator services is documented in the client file and is signed and dated.
D.6	All referrals for HIV specialty care and/or other services are documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

In addition to Universal Standards 3.0 – Transition, Discharge, and Case Closure, the objective of the transition, discharge, and case closure standards are to ensure staff support a smooth transition for clients.

#	Standard	Measure
E.1	Prior to discharging a client from services, the clinician must consult with their supervisor to decide if discharge is appropriate. When the decision is made to discharge a client, the clinician must complete a discharge summary form within 14 days.	Documentation in client file of supervisory consultation, discharge summary with specified timeframes, and relevant signatures.
E.2	If you are a prescriber of medication-assisted treatment, you must follow your agency policy for discharge.	Documentation of agency policy on file for discharge of clients utilizing medication-assisted treatment. Documentation policy followed in client's file.

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Food Bank/Home Delivered Meals

Description

According to Policy Clarification Notice 16-02, Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes provision of essential non-food items that are limited to the following:

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

Program Guidance

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

Food Bank/Home Delivered Meals services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

The overall objective of the Food Bank/Home Delivered Meals services is to:

- assess and respond appropriately to the nutritional and dietary needs of clients

Intake, Eligibility, and Recertification

#	Standard	Measure
A.1	Eligibility requirements include criteria for those who are unable or less able to purchase foods and/or prepare their own nutritionally adequate meals.	Written eligibility policy on file at agency.

Key Services Components and Activities

#	Standard	Measure
B.1	Eligibility for food bank/home delivered meals services are documented in a client file. Files must contain: • Types, dates, and location of services • Initial and subsequent food bank/home delivered meals evaluation and assessments • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service

B.2	Provision of the following services as indicated: • Provision of a voucher program to purchase food and essential non-food items that are limited to the following: ○ Personal hygiene products ○ Household cleaning supplies ○ Water filtration/purification systems in communities where issues of water safety exist	Documentation in client file of completed: • Initial food bank/home delivered meals assessment • Food bank/home delivered meals assessment updated in accordance with the care plan • The care plan specifies the types of services needed and the quantity and duration of services
B.3	Food bank/home delivered meals services should be comprehensive and should address the unique needs of people living with HIV	Progress notes signed and dated by food bank/home delivered meals provider in client file
B.4	Clients who are in need of assistance more than four times a year are referred to additional food & nutritional assistance programs. The programs include, but are not limited to: SNAP, local food pantries, commodity food programs, and congregate meals.	Documentation of supported referrals on file for clients who get assistance more than 4 times a year.

Personnel

In addition to Universal Standards 2.0 – Personnel, Food Bank/Home Delivered Meals must provide clients with the highest quality services through trained and experienced staff members.

#	Standard	Measure
B.1	Staff have the skills and experience appropriate to providing food bank/home delivered meals services.	Résumé on file.

Assessment and Service Plan

#	Standard	Measure
D.1	An initial comprehensive food bank/home delivered meals services assessment of food security is performed with the client by the appropriate provider including at a minimum: • Access to food • Access to storage • Ability to prepare meals • Dietary restrictions • Inventory of other resources clients are utilizing to meet food and nutritional needs (ie. food pantry, congregate meals, commodity food program, SNAP, etc.)	Documentation of initial comprehensive food bank/home delivered meals assessment in client file signed and dated by the provider.

D.2	A reassessment is performed with the client by the appropriate provider at the frequency established in the care plan	Documentation of reassessment in client's file signed and dated by the provider
D.3	A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. Care plans must be updated at least every six months. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
D.4	All referrals for HIV specialty care and/or other services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Housing

Description

According to Policy Clarification Notice 16-02, Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Activities within the Housing category must also include the development on an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing may provide some type of core medical or support services.

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

Program Guidance

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

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

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

Housing services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

The overall objectives of the Housing services are to:

- have appropriate policies and procedures in place to provide services;
- ensure clients are eligible for services; and
- reassess clients regularly.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Agency has a policy on file describing eligibility for housing services.	Documentation of policy on file.

B.1	Eligibility for housing services are documented in a client file. Files must also contain: • Types, dates, and location of services • Initial and subsequent housing evaluation and assessments • Individualized care plan and reassessment of care plan, inclusive of updated assessment of client progress • Dated documentation of all contacts • Dated referrals and follow-up • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service
B.2	Provision of the following services as indicated: • Transitional, short-term, or emergency housing assistance	Documentation in client file of completed: • Initial housing assessment • Housing assessment updated in accordance with the care plan • The care plan specifies the types of services needed and the quantity and duration of services
B.3	Housing services should be comprehensive and should address the unique needs of people living with HIV	Progress notes signed and dated by food bank/home delivered meals provider in client file
B.4	Agency maintains documentation of temporary and permanent housing placements.	Documentation in client file, including site, date of placement, and client and provider signatures; utilization data submitted to funder.

Personnel

In addition to Universal Standards 2.0 – Personnel, Housing must provide clients with the highest quality services through trained and experienced staff members.

#	Standard	Measure
B.1	Staff have the appropriate skills and experience to provide housing services.	Résumé on file.

Assessment and Service Plan

#	Standard	Measure
D.1	An initial comprehensive housing services assessment is performed with the client by the appropriate provider including at a minimum: • Housing barriers • Housing needs • Available resources	Documentation of initial comprehensive housing assessment in client file signed and dated by the provider.

D.2	A reassessment is performed with the client by the appropriate provider at the frequency established in the care plan	Documentation of reassessment in client's file signed and dated by the provider
D.3	A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. Care plans must be updated at least every six months. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
D.5	All referrals for housing services is documented	Documentation of each referral is signed and dated
D.6	Clients receiving assistance more than 1x per year, have a housing plan on file documenting housing goals, objectives, and supported referrals, and referral outcomes.	Documentation in client's file

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Linguistic Services

Description

According to Policy Clarification Notice 16-02, Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Program Guidance

Linguistic services provided must comply with the Universal Standards – 6.0 and the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards).

All contractors must comply with the Universal Standards – 6.0 Cultural and Linguistic Competence per federal civil rights laws requirements. Linguistic Services is a support service funded under the Non-Medical and Medical Case Management contract(s) only.

The overall objectives of Linguistic Services are to:

- assess and respond appropriately to the linguistic needs of clients;
- provide clients with the highest quality services through experienced and trained staff; and
- ensure that clients have adequate linguistic resources to understand and actively participate in the provision of Ryan White services, to accomplish health goals.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
A.1	Agency has a communication access processes and procedures in place.	Documentation of Communication Access Plan or policy on file.
A.2	Notification of the availability of language assistance services clearly visible and in their preferred language.	Visible signage in at least the top 15 languages notifying clients of the availability of language assistance services
A.3	Identification of client's language and communication access need to facilitate effective communication with service providers. The responsibility for identification rests with the provider, not with the client. If a language assistance need is suspected by the service provider, an interpreter should be offered.	Documentation of clients' preferred language or communication assistance need in client file signed and dated by the provider (e.g. spoken language interpreter, American Sign Language interpreter, Certified Deaf Interpreter, CART provider, etc).

A.4	All care/services are provided in the client's preferred language with communication access services provided as needed:
	• Interpretation: spoken or signed
	  o In-person
	  o Over the phone
	  o Video remote
	• Assistive technology
	• CART (Communication Access Real Time)
	• Translated written materials
	• Large font materials
	• etc.
		Documentation in client file whenever communication access services are provided (or waived) including date, modality, and provider/interpreter used.

A.5	Provision of easy-to-understand print and multimedia materials and signage in the regularly encountered languages commonly used by the populations in the service area. Clients have access to linguistically appropriate vital documents and significant materials, which have been translated by qualified translators.	Service providers provide commonly used educational materials and other required documents (vital documents and significant materials e.g., applications, eligibility criteria, grievance procedures, release of information, rights and responsibilities, consent forms, etc.) for each LEP language group that constitutes 5% or 1000 persons, whichever is less, of the population served. Currently Spanish meets this threshold statewide; additional languages may be needed when looking at a smaller catchment area. Strategies are employed to assure communication access when there are not translated written materials for smaller LEP language groups, such as reading the material with the assistance of an interpreter while the client jots notes and audio records the conversation.

Personnel

In addition to Universal Standards 2.0 – Personnel, Linguistic Services must provide clients with the highest quality services through trained and experienced staff members – either qualified linguistic service providers or bilingual staff.

#	Standard	Measure
B.1	Linguistic Services are provided by qualified medical interpretation and translation professionals, and/or bilingual staff, whose language competence has been assessed.	Linguistic competence and proficiency can be verified (documented on resumes, in contracts, or through testing): • Interpreters have completed 60 hours of qualifying medical interpretation training (or equivalent) and may even have certification or licensure where applicable • Bilingual staff have degree of language fluency for speaking, reading and writing assessed

Assessment and Service Plan

#	Standard	Measure
C.1	Provider and the client discuss and agree on mode of language and communication access services based on client's preference and subject to availability (i.e., in person vs over the phone vs video remote interpretation, bilingual staff member, etc.)	Documentation of method in client's file signed and dated by the provider.

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Medical Transportation

Description

According to Policy Clarification Notice 16-02, Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance

Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

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

Medical Transportation services are allowable only for people living with HIV who are eligible to receive HRSA RWHAP services.

The overall objectives of the Medical Transportation services are to:

- reimburse approved transportation services for eligible individuals living with HIV/AIDS and their caregivers;
- provide clients with the highest quality of services through trained and experienced staff;
- provide safe, timely, and reliable transportation services that facilitate access to medical and psychosocial services; and
- coordinate and administer services by qualified persons with designated administrative and program responsibilities.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Eligibility for medical transportation services are documented in a client file. Files must also contain: • Types, dates, and location of services • Initial and subsequent medical transportation evaluation and assessments • Individualized care plan and reassessment of care plan, inclusive of updated client transportation needs • Dated documentation of all contacts • Dated referrals and follow-up • All reports must be dated and signed by professional who provided the service	Client files document services that are dated and signed by the by professional who provided the service
B.2	Provision of the following services as indicated: • Taxi vouchers • Ride sharing services • Agency van • Volunteer rides • Bus vouchers/tokens	Documentation in client file of completed: • Initial medical transportation assessment • Medical transportation assessment updated in accordance with the care plan • The care plan specifies the types of services needed and the quantity and duration of services
B.3	Medical transportation services should be comprehensive and should address the unique needs of people living with HIV	Progress notes signed and dated by medical transportation provider in client file
B.4	Service provider has capacity to provide transportation that is accessible to individuals with disabilities, as required by the ADA.	Funder site visit and/or contract monitoring process
B.5	Volunteer ride programs are provided by trained volunteers who possess valid driver's licenses, liability insurance, and safe driving records	Documentation on file, including copies of driver's license, liability insurance coverage, and driving record
B.6	Vehicles that are part of van or volunteer ride programs contain first aid kits	First aid kits in van or volunteer ride vehicles. Funder site visit or contract monitoring process.
B.7	Volunteer and private transportation is provided in registered and insured vehicles	Copies of registrations and insurance coverage on file

Personnel

In addition to Universal Standards 2.0 – Personnel, Medical Transportation must provide clients with the highest quality services through trained and experienced staff members.

#	Standard	Measure
B.1	Staff or volunteers must demonstrate and maintain the following: • A current, valid driver's license with a copy kept on file • Vehicle liability insurance coverage on their vehicle • Current vehicle registration and license plates	Copies of the required documentation on file
B.2	Staff or volunteer drivers receive training on agency's policies and protocols for health and safety related incidents that outlines responsibilities, obligations, and liabilities	Signed and dated form on file by staff or volunteer. Emergency protocol for health and safety related incidents is reviewed with all staff at least once per year and is posted in the agency.
B.3	Volunteers who transport clients understand their responsibilities and obligations in the event of an accident, including the extent of their liability	Signed and dated form on file that outlines responsibilities, obligations, and liabilities
B.4	Operators of volunteer and private transportation agree to follow the established agency policy in the event of an accident	Service provider has a written accident policy on file; policy reviewed and signed by volunteer and private transportation operators and kept on file

Assessment and Service Plan

#	Standard	Measure
D.1	An initial medical transportation assessment is performed with the client by the appropriate provider	Documentation of initial medical transportation assessment in client file signed and dated by the provider.
D.2	A reassessment is performed with the client by the appropriate provider at the frequency established in the care plan	Documentation of reassessment in client's file signed and dated by the provider
D.3	A care plan must be completed after the first assessment with the client. The client is offered a copy of the care plan. Care plans must be updated at least every six months. At a minimum, it must include: • Prioritized goals individualized to the client • Established timeframes for reevaluation • Resources that may benefit the client	Documentation that a copy of the care plan was offered/provided to the client. Documentation of a care plan that is signed and dated by the provider
D.5	All referrals for other services is documented	Documentation of each referral is signed and dated

Transition, Discharge, and Case Closure
See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities
See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process
See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence
See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality
See Universal Standards 7.0 – Privacy and Confidentiality

Non-Medical Case Management Services

Description

According to Policy Clarification Notice 16-02, Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, and other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). Key activities include:

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

Program Guidance

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

Key Services Components and Activities

Clients enroll in the NH CARE Program through a contracted Non-Medical Case Management organization. Applicants must be a NH resident, are an individual living with HIV, and have a gross household income at 500% or less than the Federal Poverty Limit (FPL). Enrollment documents are provided by the client to the NH CARE Program Enrollment Coordinator via CAREWare. Re-enrollments are required every 6 months. Clients are only eligible for assistance from the NH CARE Program, while they are enrolled; services received outside of enrollment or during an enrollment lapse are the responsibility of the client. Required enrollment documents include proof of HIV status, income, residency, and an annual application to NH Medicaid (for those at or below 200% FPL). The NH CARE Program will enroll an infant born to an HIV-positive mother and pay for prophylaxis treatment, whether or not the mother is a client of the NH CARE Program.

The objective of this service category is to provide guidance and assistance in improving access to needed medical and support services including food security, housing, utilities, culture and language, legal, transportation, support systems, intimate partner violence, health insurance, and financial

assistance.

Intake, Eligibility, and Recertification

#	Standard	Measure
A.1	Client is eligible for Ryan White Part B services. To be eligible, applicants must: • Be living with HIV • Apply through a non-medical case management agency or through their medical provider • Provide a signed and dated release of information • Provide proof of residency in New Hampshire • Have a household income at or below 500% of the Federal Poverty Level • Provide proof of income • Provide proof of insurance coverage, if any • Complete a Medicaid application if household income is below 200% of the Federal Poverty Level Client must recertify for Ryan White Part B services every 6 months, up to 30 days prior to their current enrollment end date. To recertify, applicants must: • Recertify through a case management agency or through their medical provider • Provide proof of income, changes in insurance coverage, or any changes in residency • Complete an annual Medicaid application if household income is below 200% of the Federal Poverty Level	Completed documentation of eligibility in client's file.
A.2	A client awaiting a confirmatory HIV result to confirm a new HIV diagnosis is eligible for Ryan White Part B services. To be eligible, applicants must: • Provide an attestation from healthcare personnel or partner services of presumptive HIV status, which may be indicated if the person is identified as a partner of a person living with HIV and/or had a rapid positive test • Apply through a Non-Medical Case Management agency or through their	Completed documentation of eligibility in client's file.

	medical provider • Provide a signed and dated release of information • Provide self-attestation of residency in New Hampshire • Have a household income at or below 500% of the Federal Poverty Level • Provide self-attestation of income • A full application must be received within 30 days of the release of information signature date	
A.3	Case managers will meet with newly diagnosed clients or clients who have fallen out of care (e.g. do not have access to medications and/or have not had a medical visit with an HIV provider within the past 12 months), within two business days of client's request, to complete the initial assessment of service needs.	Date of client requested appointment and the date of the first initial appointment filed in client file.
A.4	Case managers will meet with clients requesting non-medical case management services (e.g., have moved to NH and was in care in previous state, clients new to the program and are in care with access to medications) within 10 business days of client's request, to complete the initial assessment of service needs.	Date of client requested appointment and the date of the first initial appointment filed in client file.
A.5	Case managers will contact client 30 days prior to enrollment end date, if client has not called. If case manager does not hear from the client after two weeks, the case manager will reach out to client by preferred method of contact. During the week prior to expiration, the case manager shall make one last attempt to reach the client.	Documentation of attempted contacts in client file.
A.6	Non-Medical Case Management agencies promote continuity of care with Medical Case Management agencies, if agencies differ.	MOUs on file with Medical Case Management agencies as well as procedure for ensuring continuity of care.

Personnel

In addition to Universal Standards 2.0 – Personnel, Non-Medical Case Management must provide clients with the highest quality services through appropriately trained and experienced staff including both medically credentialed and other staff who are part of the care and support team. The objectives of personnel standards for Non-Medical Case Management are to:

- Provide the highest quality of care through experienced and trained case managers;

- Provide case managers with quality supervision; and
- Inform case managers/case management supervisors of their job responsibilities.

HIV non-medical case managers work with clients and develop a supportive relationship, enable clients to reach their self-sufficiency goals, and facilitate access to and use of available services for which they are eligible, as well as community resources. At a minimum, all case managers hired by provider agencies will be able to demonstrate the ability to determine unmet support needs, provide information and referrals for support and care services, complete documentation as required by their position, and demonstrate previous experience in the human service delivery field.

All HIV case managers and case manager supervisors will be given a written job description that outlines specific minimum qualifications. All HIV case managers will complete the NH Case Manager Curriculum as outlined by the NH CARE Program within 3 months of date of hire.

#	Standard	Measure

B.1	Newly hired Non-Medical HIV Case Managers must meet a minimum of one of the following criteria:
	• A trained health or social service professional credentialed in their field according to New Hampshire certification requirements; or
	• A trained individual which includes a minimum of one of the following criteria:
	  • Bachelor's degree with one (1) year experience in human services-related field, such as: social work; psychology; counseling; or health education; or
	  • Associate's degree with two (2) years of experience in a human services related field; or
	  • High school diploma or GED with two (2) years of experience in a human services related field.
		Job description on file that describes minimum qualifications of standard.
		
		Résumé or documentation in personnel file meeting minimum requirements of the job description.

B.2	Newly hired HIV case managers have at least the following qualifications: • Ability to complete documentation required by the case management position; and • Experience and/or education consistent with the job description.	Job description on file that describes minimum qualifications of standard. Résumé in personnel file meeting minimum requirements of the job description.

B.3	Newly hired or promoted HIV case manager **supervisors** have the minimum qualifications described above for case managers plus five years of case management experience or other experience relevant to the position (e.g., volunteer management).	Résumé in personnel file meeting minimum requirements of standard.
B.4	Newly hired case managers will complete the Case Manager Curriculum as outlined by the NH CARE Program within 3 months of date of hire.	Signed documentation of completed training on file.
B.5	Personnel receive at least one hour of administrative supervision per month.	Signed documentation on file indicating the date of supervision, type of supervision (administrative or clinical), and name of supervisor.
B.6	Case managers (1.0 FTE) have a minimum of twenty-five (25) active clients and a maximum of fifty (50) active clients.	Files exist for at least twenty-five (25) active clients for each 1.0 FTE case manager. Written justification for any caseload size of less than twenty-five (25) clients per 1.0 FTE case manager must be on file at the agency. Written justification for any caseload size of more than fifty (50) clients per 1.0 FTE case manager must be on file at the agency.

Assessment and Service Plan

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

A Case Management Assessment Form has been provided by the State of NH DPHS. Agencies may use their own form, but assessments must address at minimum the following components:

- Basic information about the client;
- Food Security;
- Housing/Living Situation;
- Utilities;
- Culture Language;
- Legal;
- Transportation;
- Support System;
- Intimate Partner Violence;
- Health Insurance; and
- Financial.

A Case Management Acuity Scale piloted by the State of NH DPHS is available. Agencies are encouraged

but not required to use this scale and other evidence-based assessment tools as directed by the program.

Based on the information collected during the intake and initial assessment, the case manager will create a customized Individual Service Plan (ISP) with the client. The ISP serves as the road map for the client's progress through the HIV service system and will include measureable goals and objectives that encourage client self-sufficiency. The ISP should include specific services needed and referrals to be made including timeframes and a plan for follow-up. The ISP should address harm reduction and positive prevention, if the assessment indicates a need in these areas ISP must be completed within 30 days of the initial intake date and must be reviewed and approved by the case management clinical supervisor.

Assessment and service planning are ongoing processes. It is the responsibility of the case manager to reassess and document a client's needs and his/her ISP as needed but no less than once every six (6) months.

#	Standard	Measure
C.1	Comprehensive initial assessment is completed within 30 days of intake, to assess service needs in the following areas: • Basic information about the client; • Food Security; • Housing/Living Situation; • Utilities; • Culture Language; • Legal; • Transportation; • Support System; • Intimate Partner Violence; • Health Insurance; and • Financial.	Completed case management assessment form in the client file.
C.2	Individual service plan (ISP) is completed collaboratively with the client within 30 days of intake and includes short-term and long-term goals, action steps to address each goal, specific services needed and referrals to be made, barriers and challenges, a timeline, and a plan for follow- up.	In addition to having the client's and case manager's signature, a completed ISP is reviewed, approved, and signed by the case management clinical supervisor and stored in client's file.
C.3	Reassessment of client needs is completed as needed, but not less than once every six months. At least once per year, re-assessment must be conducted face-to-face.	Documentation of reassessment in client's file, including whether the re-assessment was conducted over the phone or face-to- face.

C.4	Case managers will continuously monitor client progress to assess the efficacy of the ISP. Case managers will re-evaluate the ISP at least every 6 months with adaptations as necessary. At least once per year, re-assessment must be conducted face-to-face.	Documentation of client progress towards goals developed in service plan, including whether the re-assessment was conducted over the phone or face-to- face.
C.6	Case managers will provide timely and coordinated access to medically appropriate levels of health and support services to ensure continuity of care	Documentation of supported referrals to appropriate medical and support services documented in client file including, date supported referral offered and client acceptance or denial of referral.
C.7	Case management supervisor conducts a quality assurance file review at least quarterly following the six month assessment/reassessment to ensure that client files meet standards.	Documentation in client's file or separate location (e.g., binder).
C.8	Licensed clinician will meet with case managers and sign off on service plan within 30 days of service plan development.	Documentation of signature in client file.
C.9	Each agency will have a documented clinical supervision procedure. At the minimum, it should include the frequency and the information that will be reviewed during clinical supervision.	Written procedure on file at provider agency; signed documentation of clinical supervision review on file.

Transition, Discharge, and Case Closure

In addition to Universal Standards 3.0 – Transition, Discharge, and Case Closure, the objective of the transition, discharge, and case closure standards are to ensure staff support a smooth transition for clients.

#	Standard	Measure
D.2	Case managers will support clients who inform them that they will move out of state or jurisdiction, or who will become over income for services by the NH CARE Program, in identifying additional resources.	Documentation of support of transition planning in client file.

Client Rights and Responsibilities

See Universal Standards 4.0 – Client Rights and Responsibilities

Grievance Process

See Universal Standards 5.0 – Grievance Process

Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Other Professional Services

Description

According to Policy Clarification Notice 16-02, Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Services include:

- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

Program Guidance

The only funded NH service under Other Professional Services is for income tax preparation services to assist people living with HIV who are eligible to receive HRSA RWHAP services in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

The overall objectives of the Other Professional Services are to:

- Ensure that clients who are enrolled in ACA plans have access to confidential federal tax preparation services;
- Ensure that the NH CARE Program has a documented process for vigorous pursuit of necessary tax documents from clients, resulting from the payment of health insurance premiums on behalf of clients.

Intake, Eligibility, and Recertification

See Universal Standards 1.0 – Intake, Eligibility, and Recertification

Key Services Components and Activities

#	Standard	Measure
B.1	Service provider is authorized by the Internal Revenue Service (IRS) to provide federal tax preparation services.	Copy of IRS agreement/certificate on file at service provider

Personnel

In addition to Universal Standards 2.0 – Personnel, Other Professional Services must provide clients with the highest quality services through trained and experienced staff members.

#	Standard	Measure
B.1	The individual delivering Other Professional Services must be a Certified Public Accountant, Tax Attorney or registered as an IRS Tax Preparer	Résumé and certificate/license on file.

Transition, Discharge, and Case Closure

See Universal Standards 3.0 – Transition, Discharge, and Case Closure

Client Rights and Responsibilities

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Grievance Process

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Cultural and Linguistic Competence

See Universal Standards 6.0 – Cultural and Linguistic Competence

Privacy and Confidentiality

See Universal Standards 7.0 – Privacy and Confidentiality

Glossary of Terms and Acronyms

ADA – Americans with Disabilities Act

AETC – AIDS Education & Training Center

AIDS – Acquired Immune Deficiency Syndrome

ASAM - American Society of Addiction Medicine

ASO – AIDS Service Organizations

CARE – Comprehensive AIDS Resources Emergency

CAREWare – Software for managing and monitoring HIV clinical and supportive care

CARF - Commission on Accreditation of Rehabilitation Facilities

DHHS – Department of Health and Human Services

DPHS – Division of Public Health Services

EIS – Early Intervention Services

FTE – Full Time Equivalent

HIPAA – Health Insurance Portability and Accountability Act

HIV – Human Immunodeficiency Virus

HRSA - Health Resources and Services Administration

ISP/CAP - Individual Service Plan/Client Action Plan

LADC – Licensed Alcohol and Drug Counselor

MLADC – Master Licensed Alcohol and Drug Counselor

Licensed Clinician – Refer to www.oplc.nh.gov for applicable qualifications

LICSW - Licensed Clinical Social Workers

LMFT – Licensed Marriage and Family Therapist

LMHC – Licensed Mental Health Counselors

MAT – Medication Assisted Therapy

MOA – Memoranda of Agreement

MOU – Memoranda of Understanding

PP – Pastoral Psychotherapist

PrEP – Pre-exposure Prophylaxis

RWHAP - Ryan White HIV/AIDS Program

Appendix A

Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

BUREAU OF INFECTIOUS DISEASE CONTROL

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4496 1-800-852-3345 Ext. 4496
Fax: 603-271-0545 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

Bureau of Infectious Disease Control
Oath to Maintain Security and Confidentiality for Contractors

I understand that through my contract or other agreement with the Bureau of Infectious Disease Control, I may have access to information in various forms (electronic, paper, verbal communications, etc) that identifies individuals and their health information. I understand that this type of information must remain confidential and the identities of the individuals must be protected.

I have read, understand and agree to follow the confidentiality and informed consent laws (RSA 141-C:10, RSA 141-F:8 and RSA 141-F:9), the Medical and Scientific Research Information law (RSA 126-A:11), and the Bureau's security and confidentiality policy.

Furthermore, I agree to follow the rules below:

- I will not purposefully or inadvertently disclose the identities of individuals who are or are thought to be infected with infectious diseases or affected by exposures or illness, to other persons, agencies or organizations unless authorized to do so as part of my work.
- I will not scan or read paper or electronic documents containing protected health information unless it is necessary for my work.
- I will not permit other people to make copies of paper or electronic documents containing protected health information unless it is necessary for my work or unless authorized to do so.
- I will handle all paper or electronic documents carefully and I will not leave them open for other people to see or take. All documents with identifiers that can be destroyed will be shredded. Documents that need to be saved will be placed in locked file cabinets when I am not using them.
- I will only mail or fax protected health information in accordance with the Bureau's policy.
- I will not email protected health information or provide this type of information through any other electronic mechanism (including storage on flash drives, laptops, or other portable devices) unless the information is encrypted and the method is in accordance with the Bureau's policy.
- I will protect paper and electronic documents from physical and mechanical damage.
- I will use computer and other security measures to prevent unauthorized people from accessing confidential information. I will not tell unauthorized people my computer passwords.
- I will hold conversations that involve identifying information, including telephone conversations and conference calls, only in confidential work areas unless authorized to do otherwise.
- I will report any possible or suspected unauthorized release (i.e. breach) of protected health information to my supervisor.

I understand that if I violate any of the above rules, disciplinary and legal action may be taken against me.

Date: _____ Printed Name: _____Signature: _____

Organizational Affiliation: _____