MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Ryan White Program
Service Standards

Updated February 2019 (Revision 5/22/2020)
MDHHS HIV CARE & PREVENTION SECTION

Contents

INTRODUCTION

Michigan Department of Health and Human Services (MDHHS), HIV Care Section (HCS) is the Michigan grantee of the federal Ryan White Part B funds, issued by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). These funds aim to provide services to people living with HIV (PLWH) who have no health insurance (public or private) or insufficient health care coverage and lack financial resources to access care aimed at improving health outcomes, and patient satisfaction (hab.hrsa.gov).

All Ryan White funding supports services that fill gaps left by other funding sources and address the social determinants of health that contribute to HIV-related health disparities.

MDHHS/HCS activities are aligned with the National HIV/AIDS Strategy (NHAS) developed by the White House Office of National AIDS Policy and updated to 2020 goals (see NHAS updated to 2020). In accordance with NHAS goals and HRSA/HAB guidelines, MDHHS/HCS programs aim to:

- Reduce New HIV Infections
- Increase Access to Care and Improving Health Outcomes for PLWH
- Reduce HIV-Related Health Disparities and Health Inequities
- Identify and link to medical care people who were previously unaware of their HIV status
- Reengage PLWH who are lost to medical care
- Support PLWH in maintaining ongoing HIV medical care
- Provide resources to address social determinants and reduce HIV-related health disparities
- Assist PLWH to achieve positive health outcomes, including HIV viral load suppression

To accomplish these goals, MDHHS/HCS funds, Ryan White core medical and support services. Seventy-five percent of Ryan White funds are utilized for core medical service categories, which include services that directly focus on medical or clinical activities. On the other hand, twenty-five percent of Ryan White funds are used for support service categories, which provide wrap-around services that address psychosocial barriers to medical care adherence.

This document outlines the Ryan White Part B Service Standards for all MDHHS/HCS-funded Part B programs. The purpose of these standards is to ensure the quality and consistency of MDHHS-funded Ryan White core medical and support service categories throughout the state.

In reviewing the items within this document, it is important to keep the following in mind:

- In addition to being adherent to these Service Standards, it is also important to adhere to the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B and Updated Policy Notices and Program Letters from HRSA. HRSA/HAB standards take precedence over MDHHS/HCS Service Standards.
- Policy Notices and Program Letters
- Items in the Universal Standards apply to all service categories.
- Additional program information related to a service category is provided in the Appendix. These items are subject to change based on grant and contract requirements.
- Throughout the document, the term client or patient refers to individuals being served by a Ryan White program, and this term is used interchangeably.
- This is a living document and may change based on HRSA/HAB requirements, the needs of PLWH in Michigan, and the services offered by providers. MDHHS/HCS will actively work to keep this document updated. To provide comments regarding this document or considerations for future revisions, please contact MDHHS/HCS at 517-241-5900.

UNIVERSAL STANDARDS

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

STANDARD	MEASURE
Access to Care	
a. Structured and ongoing efforts to obtain input from clients for the design and delivery of services and use of evaluation results to improve service delivery	• Documentation of Client Advisory Board and meeting minutes at least annually • Documentation of client input mechanisms (surveys, suggestion box) at least annually • Documentation of the use of client input in training and staff communication • Quality Improvement plan • Modification to service delivery from feedback if applicable
b. Services are provided irrespective of inability to pay, current or past medical conditions, age, race, physical or mental challenges, criminal history, substance use, immigration status, veterans, or gender identity or expression.	• Policies and Procedures
c. Services are provided in accordance with the Americans with Disabilities Act guidelines. For more information, refer to: ADA of 1990, as amended	• Policies and Procedures
d. Translator or interpreter services are available for those clients who are in need.	• Policies and Procedures • Program literature in applicable language of clientele served
e. Provide written instructions for clients with regards to accessing services after business hours.	• Policies and Procedures • Written information provided to the client
HIV Continuum of Care	
a. Establish formal collaborative agreements with HIV and other agencies as	• Memorandum of Agreements or Understanding
b. Inform clients of the various HIV services and resources available throughout Michigan	• Documentation in client records of resources given • Written resources provided to the client
c. Resources and referral tracking system with identified service providers • Follow up with resources and referrals	• Policy and Procedure for referrals and tracking referrals • System of tracking • Documentation in client records of referrals given and followed up

Staff Requirements	
a. Provide staff with their job descriptions that address minimum qualifications, core competencies, and job responsibilities.	• Job descriptions
b. Staff training that ensures services are provided in a culturally competent, compassionate, non-judgmental, and comprehensible manner.	• Training certificates or sign-in sheets from in-services • Client satisfaction surveys Client Grievances
c. Ensure that staff has attended and completed all required training within the first year of hire. • Medical Case Management training • Early Intervention training • HIV test counseling For more information, refer to: HRSA Service Standards	• Provide written assurances and maintain documentation showing that medical case management and EIS services are provided by trained professionals who are either medically credentialed or qualified health care staff and operate as part of the clinical care team
d. Ensure that staff and contracted service providers delivering direct services to clients and have knowledge of: • HIV/AIDS disease process • Effects of HIV/AIDS-related illnesses and co-morbidities on clients • Psychosocial effects of HIV/AIDS on clients and their families/significant others • Current strategies for the management of HIV/AIDS • HIV-related resources and services in Michigan For more information, refer to: DHHS Guidelines.	• Documentation of this knowledge via formal education, training, or other methods. (degree, licenses/certifications, training certificates, transcripts, etc.) • Staff interview
e. Ensure that staff and contracted service providers follow, at minimum, established codes of conduct for their discipline.	• Policies and procedures • Code of Conduct • Training certificates or sign-in sheets from in-services Staff interview
f. Ensure that staff and contracted service providers receive ongoing supervision that is relevant and appropriate to their professional development	• Supervisory/case conference meeting logs • Documentation of supervisory client record reviews • Documentation of professional development associated with HIV Medical Information

STANDARD	MEASURE
Staff Requirements Continued	
a. Ensure that staff and contracted service providers conduct business in a manner that ensures the confidentiality of clients and follows established protocols outlined in the Health Insurance Portability Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) and the Michigan Public Health Code. Ensure that staff receives annual training on the Health Insurance Portability Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH), and the Michigan Public Health Code. For more information, refer to: HITECH Act and HIPPA.	• Policies and procedures • Training certificates or sign-in sheets from in-service • Staff signatures on agency's Confidentiality/HIPAA/ HITECH statements • Staff interview
Safety and Emergency Procedures	
a. Ensure that services are provided in facilities that are clean, comfortable, and free from hazards.	• Site visit observation
b. Provide policies and procedures for the following: • Physical Plant Safety • Emergency Procedures that include fire, severe weather, and intruder/weapon threat • Accident / Incident Reporting Ensure that staff and contracted service providers, if residing in your facility, are trained and following the safety and emergency procedures.	• Policies and procedures • Site visit observation • Training certificates or sign-in sheets from in-service • Staff interview
c. Follow recommended Occupational Safety and Health Administration (OSHA) and the Michigan Occupational Safety and Health Administration (MIOSHA) regulations.	• Policies and procedures • Site visit observation • Training certificates or sign-in sheets from in-service • Staff interview
Eligibility and Recertification Requirements	
a. Verify proof of HIV status, income, residency, and insurance in accordance with the MDHHS Ryan White Program Guidance #14-01 and every six months. www.michigan.gov/documents/mdhhs/RW_Guidance_14-01_-_Eligibility_Revised_10.05.2015_515154_7.pdf	• Policies and procedures • Documentation in client records of established eligibility and recertification within specified timeframes
b. Proof of HIV status must be established within 30 business days of intake or initial assessment, whichever comes first.	• Policies and procedures • Documentation in client records of established HIV status within a specified timeframe
c. If a client is not enrolled in an insurance plan, providers must assist the client with benefits counseling and enrollment into an appropriate insurance plan.	• Policies and procedures • Documentation in client records of benefits counseling/enrollment

STANDARD	MEASURE
Intake	
a. Complete an intake with clients within five business days of initial contact or begin the initial biopsychosocial assessment. If an intake form is completed or initial assessment is started, it should, at minimum, include the required elements in the Ryan White Service Program Report (RSR). The most recent version can be found at: RSR	• Intake forms and documentation in client records of completed intake and/or initial assessment
Consents and Related Client Documentation	
a. Obtain and Document the following within 30 days of intake or initial assessment, whichever comes first. Consents are needed upon entry into care and services. The release of Information is to be signed yearly. • Informed Consent for RW services • Client Rights and Responsibilities ▪ Services offered ▪ Conditions of services ▪ Termination of services ▪ Transfer and discharge procedures ▪ Access to records ▪ Appointment attendance ▪ Acts of abuse ▪ Drug and alcohol on facility premises • Confidentiality • Client Grievance Procedure • Release of Information ▪ To whom and what can be released ▪ Time limits not to exceed one year ▪ The printed signature of the client or legal guardian ▪ Signature of witness • Service Plan of Care	• Policies and procedures • Consent to Serve forms • Client Rights and Responsibilities forms • Grievance forms • Release of information forms • Confidentiality forms • Care Plans/Service Plan forms • Reporting of unresolved grievances to MDHHS within three business days.
b. Ensure clients records are maintained in a secure location and are protected	Policy and procedures that include: • Secure fax • Secure records • Secure phone • Secure emails • Secure transport of records • Secure records • Staff interviews • Site visit observation

STANDARD	MEASURE
Discharge from Services	
a. Discharge from services must occur with any of the following: • Completion of Services • Client or legal guardian request • Client death • Verification of HIV status or Eligibility is not obtained within 30 days • Relocation of a client outside of agency service area • The client wishes to transfer to another service provider • The client needs are more appropriately addressed through another provider • Inability to contact the client for more than 90 days	• Policy and procedure • Documentation in the client record, for the reason of the discharge • Attempts to reach client if unable to locate within 90 days • Notification of discharge to the client

OUTPATIENT AND AMBULATORY HEALTH SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include clinics, medical offices, mobile vans, telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include: Medical history taking, Physical examination, diagnostic and laboratory testing (including HIV confirmatory and viral load testing), treatment and management of physical and behavioral health conditions, behavioral risk assessment, subsequent counseling, and referral, preventive 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, and including audiology and ophthalmology.

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.

Non-HIV related visits to urgent care facilities are **NOT** allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. HIV primary healthcare clinics must be licensed and where applicable, accredited to deliver primary medical care.	• Copy of valid Michigan license
b. Ryan White Clinic staff and contracted services providers must have a current license or certification within the professional scope of practice and as required by the State of Michigan	• Copy of valid Michigan license or certification
Service Delivery	
a. Core elements of HIV primary care **must** include: □A complete medical history and physical exam including an oral exam □Laboratory tests 1. HIV antibody testing if prior documentation is not available or if HIV RNA is below the assay's limit of detection. 2. Genotypic resistance testing, for patients who have HIV RNA levels <500 to 1,000 copies/mL, viral amplification for resistance testing may not be successful 3. CD4 count upon entry into care and repeating every 3-6 months in patients who have not initiated ART. In patients on ART, CD4 count monitoring should also be performed every 3-6 months during the first two years of ART or if viremia develops while the patient is on ART. After two years on ART with consistently suppressed viral load, the CD4 count can be tested every 12 months in those with a CD4 count between 300 and 500 cells/µL; CD4 count monitoring is optional in those with a CD4 count over 500 cells/µL. 4. Plasma HIV Viral load upon entry into care, and ART initiation or modification, patients on ART, the viral load is measured every 3-4 months. However, in adherent patients with consistently suppressed viral load and stable immunologic status for more than two years, monitoring can be extended to every six months. 5. Complete Blood Cell (CBC) Count upon entry into care and monitor every 3-6 months and upon ART initiation or modification. 6. Complete metabolic profile upon entry into care and monitor every 3-6 months and upon ART initiation or modification. 7. Urine analysis upon entry into care and at ART initiation or modification and monitor every 12 months (or every six months in patients on tenofovir disoproxil fumarate or tenofovir alafenamide). More frequent monitoring may be indicated in patients with evidence of kidney disease. 8. Lipid profile upon entry into care, at ART initiation or modification, and every 6-12 months if the prior measurement was abnormal or normal, respectively.	• Documentation in client records of specified core elements

9. Glucose or glycated hemoglobin A1C (preferably fasting) or glycated hemoglobin A1C (HbA1C) upon entry into care, upon ART initiation or modification, and every 6-12 months if the prior measurement was abnormal or normal, respectively. 10. Hepatitis A virus antibody (HAV) immunoglobulin G (IgG) antibody test is negative, offer the patient vaccination 11. Hepatitis B virus (HAB) infection status tested upon entry to care, including measurement of hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (HBsAb), and antibody to hepatitis B total core antigen (anti-HBc or HBcAb). Those who are susceptible to infection should be vaccinated against HBV 12. Hepatitis C virus (HCV) antibody testing upon entry to care and annually thereafter for those at risk. If positive, confirm the result with HCV RNA 13. Toxoplasma gondii IgG, if negative, repeat if the patient becomes symptomatic or when the CD4 count is below 100 cells/µL. If the result is positive, initiate prophylaxis when the CD4 count is below 100 cells/µL. 14. Tuberculosis screening (TB) upon entry into care via either a tuberculin skin test (TST) or an interferon-gamma release assay (IGRA). Patients with positive test results should be treated for latent M tuberculosis infection after acute TB has been excluded. Patients who are close contacts of persons with infectious TB should be treated for latent M tuberculosis infection regardless of their TST results, age, or prior courses of TB treatment after the diagnosis of active TB has been excluded. Baseline Chest radiographs should be obtained in all patients with a positive TST result to rule out active disease. 15. Papanicolaou testing in women: If a cervical Papanicolaou test yields normal findings, repeat after six months and then annually thereafter. If the results are abnormal, further evaluation should be performed as indicated. 16. Anal cancer screening: HIV-infected men and women with human papillomavirus (HPV) infection are at increased risk for anal dysplasia and cancer, particularly men who have sex with men (MSM). Anal cancer is the fourth most common cause of cancer in patients with HIV infection or AIDS. Anal cytologic screening (anal Papanicolaou test) is recommended in MSM, women with a history of receptive anal intercourse or abnormal cervical Papanicolaou test results, and all HIV-infected persons with genital warts. 17. Syphilis screening upon entry into care and at least annually in sexually active HIV-infected persons and frequent screening (every 3-6 months) in those considered high risk. A lumbar puncture should always be performed in patients with a reactive syphilis serology who have neurologic or ocular symptoms or signs (irrespective of past syphilis treatment) and in those who experience serologic treatment failure.	

18. Herpes viruses, CMV infection should be tested for latent CMV infection with an anti-CMV IgG test upon initiation of care. Patients who do not have evidence of immunity to varicella should receive post-exposure prophylaxis with VARIZIG as soon as possible (but within 96 hours) after exposure to a person with varicella or shingles. Varicella primary vaccination may be considered in HIV-infected, VZV-seronegative persons aged 18 years with CD4 cell counts at or above 200 cells/µL.

- Immunizations
  1. Hepatitis A vaccine Administer to susceptible MSM, as well as others with indications for hepatitis A virus vaccine. If vaccinated, serologic response should be checked one month after completion of series, and non-responders should be revaccinated.
  2. Hepatitis B vaccine administers to patients without evidence of past or present hepatitis B infection, Anti-HBV surface Ab titers should be checked one month after completion of vaccine series; if the titer is 10 IU/mL or less, then revaccinate. Higher-dose booster or series may be considered in non-responders.
  3. Human papillomavirus vaccine, quadrivalent HPV vaccination should be given to all HIV-infected males and females if not previously vaccinated
  4. Influenza vaccine administered yearly. Inactivated influenza vaccine is recommended; do not use the live attenuated intranasal vaccine.
  5. Pneumococcal vaccine, all patients with a CD4 count above 200 cells/µL should receive a dose of PCV13 (Prevnar 13), followed by a dose of PPV23 (Pneumovax) at least eight weeks later. If previously vaccinated with PPV23, give PCV13 at least one year after PPV23. A second PPV23 dose is recommended five years after the first PPV23 dose.
  6. Measles, mumps, and rubella (MMR), Live vaccine is contraindicated for use in patients with severe immunosuppression (CD4 count < 200 cells/µL). Administer to all nonimmune persons with CD4 counts of 200 cells/µL or more.
  7. Varicella-zoster vaccine (VZV), Live vaccine is contraindicated in patients with severe immunosuppression (CD4 count < 200 cells/µL). Consider for HIV-infected, VZV-seronegative persons with CD4 counts of 200 cells/µL or more.
  8. Meningococcal conjugate vaccine, routine immunization with meningococcal conjugate vaccine
- Pneumocystis pneumonia (PCP) prophylaxis as applicable • CD4 count <200 cells/mm3, or CD4 <14%, or CD4 count >200 but <250 cells/ mm3, if monitoring CD4 cell count every 3 months is not possible, Note: Patients who are receiving pyrimethamine/ sulfadiazine for treatment or suppression of toxoplasmosis do not require monitoring every three months

• Prescriptions for prophylaxis and/or treatment of opportunistic infections • Medication adherence counseling • Screening and/or referral for mental health/substance abuse treatment and counseling, mental health/depression screening, tobacco use screening, preconception health screening, and medical case management • Assessment of high-risk behaviors at every visit and/or referral to provide HIV prevention education • Screenings for clinical trials, as appropriate • Treatment adherence counseling and education • Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology with reports returned from care • Services are as part of the treatment of HIV • All medical notes inpatient records are signed by a licensed provider For more information, refer to: DHHS Guidelines. https://aidsinfo.nih.gov/guidelines	
b. The medical care provider works in partnership with the client to offer adequate information about their health and patient-centered treatment options	• Documentation in client records of instructions and education regarding treatment options • Documentation in client records of interventions to assist adherence to plan of care

EARLY INTERVENTION SERVICES (EIS)

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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. HRSA RWHAP Part B recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

HRSA RWHAP Parts A and B EIS services must include all four components to be present, but Part A/B funds to be used for HIV testing only as necessary to supplement, not supplant, existing funding" (2013 HRSA/HAB National Monitoring Standards—Part B).

1. Targeted HIV testing to help the unaware learn of their HIV status and receive a referral to HIV care and treatment services if found to be living with HIV.
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
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 HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
4. Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

CAREWare Data Definitions

Refer to the most recent MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent MDHHS Summary of Performance Measures (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Ensure staff and contracted service providers complete HIV counseling testing and referral and EIS training by MDHHS within one year of hire.	• Training certificates for appropriate EIS Staff
Assessment of Needs	
a. Initial assessment of the client must include • Barriers to medical care • Psychosocial needs • Health education, risk reduction, and health literacy needs	• Documentation in client records assessment of identified areas
Linkage to Medical Care and Support Services	
• Link clients to healthcare and supportive services • Health Insurance • HIV Medical Care Appointments • AIDS Drug Assistance Program (ADAP) • Supportive Services Identified by Assessment of Needs • Releases of Information for Medical care providers and Nutritional/Mental Health Providers if applicable	• Link clients to healthcare and supportive services • Health Insurance • HIV Medical Care Appointments • AIDS Drug Assistance Program (ADAP) • Supportive Services Identified by Assessment of Needs • Releases of Information for Medical care providers and Nutritional/Mental Health Providers if applicable
Health Education, Risk Reduction and Health Literacy	
a. EIS must offer ongoing education to clients on the following and ensure client knowledge: • HIV 101 • Medication and Treatment Adherence • Available Resources • Navigating the HIV System of Care	• EIS must offer ongoing education to clients on the following and ensure client knowledge: • HIV 101 • Medication and Treatment Adherence • Available Resources • Navigating the HIV System of Care
Documentation	
a. Document all contacts, efforts, and services with client in CAREWare under case notes, and service tab with an accurate number of service units	• Document all contacts, efforts, and services with client in CAREWare under case notes, and service tab with an accurate number of service units

STANDARD	MEASURE
Discharge	
a. Work with clients for a maximum of 6 months to facilitate linkage to care. This timeframe can be extended with supervisor approval.	a. Work with clients for a maximum of 6 months to facilitate linkage to care. This timeframe can be extended with supervisor approval.
b. Ensure a client-centered discharge plan that includes connections to other resources as identified according to client needs.	b. Ensure a client-centered discharge plan that includes connections to other resources as identified according to client needs.

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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

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 standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost-sharing on behalf of the client.

To use HRSA RWHAP funds for health insurance premium assistance (not standalone dental insurance 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
- 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 (HRSA RWHAP Part A, HRSA RWHAP Part B, HRSA RWHAP Part C, and HRSA RWHAP Part D).

To use HRSA RWHAP funds for standalone dental insurance premium assistance, and HRSA RWHAP Part recipient must implement a methodology that incorporates the following requirement:

- HRSA RWHAP Part recipients must assess and compare the aggregate cost of paying for the standalone dental insurance option versus paying for the full cost of HIV oral health care services to ensure that purchasing standalone dental insurance is cost-effective in the aggregate, and allocate funding to Health Insurance Premium and Cost-Sharing Assistance only when determined to be cost-effective.

Traditionally, HRSA RWHAP Parts A and B recipients have supported paying for health insurance premiums and cost-sharing assistance. If an HRSA RWHAP Part C or Part D recipient has the resources to provide this service, and equitable enrollment policy must be in place and it must be cost-effective. HRSA RWHAP Parts A, B, C, and D recipients may consider providing their health insurance premiums and cost-sharing resource allocation to their state HRSA RWHAP ADAP, particularly where the ADAP has the infrastructure to verify health care coverage status and process payments for public or private health care coverage premiums and medication cost-sharing.

See PCN 14-01: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

See PCN 18-01: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost-Sharing Assistance (PCN 18-01)

Purpose of Expenditure Monitoring

Health Insurance Premium & Cost-Sharing Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of Health Insurance Premium & Cost-Sharing Assistance funding provided.

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent MDHHS Summary of Performance Measures (Appendix B).

STANDARD	MEASURE
Support for HIPCA	
a. Requests from a client for HIPCA funds b. The Case Manager will supply the client with relevant agencies/resources that may be able to assist with coverage (MIDAP, IAP, Premium Assistance, Medicaid etc.). c. Case Manager will assist the client in applying for relevant coverage d. Evidence of application to relevant agencies must be demonstrated. e. Upon supplying proof of agencies'/resources' denial and/or inability to assist the client in a timely manner, the client may request HIPCA. The client will provide relevant documentation and information necessary for the Case Manager to complete the HIPCA funds request form. f. Denials from other agencies must accompany the request for HIPCA funds as appropriate. g. The HIPCA request form will be completed by the Case Manager and provided to agencies Division Director/Supervisor who will review and approve or deny the request. h. If the request is approved, the request form and related documents are forwarded to MDHHS fax line i. MDHHS will review the request and approve or deny and will document approval or denial in CAREWare notes. j. Following the approval of a 1st HIPCA request, and prior to a 2nd request, the client will be responsible for preparing a personal/household budget and review with their Case Manager. k. All HIPCA requests and supportive documentation will be held on file by the agency. l. All services are documented in CAREWare by the requesting agency utilizing MCM or NMCM support sub-service category.	• Documentation of the need for HIPCA and supporting documents • Retain all documents on file at the agency

HOME AND COMMUNITY-BASED HEALTH SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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.
Services include:

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

Inpatient hospitals, nursing homes, and other long-term care facilities are NOT considered an integrated setting for the purposes of providing home and community-based health services. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of home and community-based on health services. Standards can be found at: State of Michigan Home Health Agency Provider Standards	• A copy of a valid license or proper credentialing in the State of Michigan
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of Home and Community Based Health Services. The following are not considered an allowable location: • Inpatient hospitals • Nursing homes • Long-term care facilities	• Site visit observation • Site visit description
STANDARD	**MEASURE**
Service Delivery	
a. Medical team referral for Home and Community-Based Health Services established to meet the client needs related to HIV	• Documentation from the medical provider/team of the need for home and community-based health services
b. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services	• Documentation of location of services • Documentation of treatment modalities in the client record
c. Assessment of needs	• Documentation of needs in the client record
d. Care Plan/Service Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and Home and Community-Based Health Services health care provider	• Referral for home and community-based health services • Documentation of Care Plan/Service Plan in client records
d. Care Plan/Service Plan updated on on-going basis and at a minimum of every six months	• Updated Care Plan/Service Plan in client records

STANDARD	MEASURE
Reauthorization of Services	
a. Re-authorized services per the following: • Nursing, speech, physical, and occupational therapy services must be reauthorized by a physician every 60 days. • All other services (e.g., home health aide) must be reauthorized every 120 days. Reauthorization decisions must be made in conjunction with the nurse, physician, and other staff (e.g., medical case manager) as appropriate.	• Evidence in client records of reauthorization
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services	• Evidence in client records and CAREWare of services, units and case notes

MENTAL HEALTH SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Mental Health Services is 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. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Ensure that staff and contracted service providers are mental health professionals currently licensed in Michigan to provide such services. (psychiatrists, psychologists, or licensed clinical social workers)	• A copy of valid Michigan license or proper credentialing
Service Delivery	
a. Assessment of mental health care needs and documentation of client mental health diagnosis	• Documentation of needs in the client record • Documentation of mental health diagnosis
b. Coordinated services with client medical care and support services, including medical case management	• Evidence in client records of coordination with other service providers
c. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes

Service Delivery continued	
d. The treatment plan developed collaboratively with the client within 30 days of referral for services. Treatment plan must include: • Clinical mental health diagnosis • Description of the need(s) • Action steps/interventions to address the need(s) • Treatment modality • Timeframes to address the need, including the recommended number of sessions • Dated signatures of the client and mental health treatment provider	• Evidence in client records of treatment plan • Treatment plan dated and signed
e. Ongoing assessment of the need for mental health services and complete reassessment at a minimum of every six months	• Evidence of assessment every six months
f. Assess ongoing the need for other mental health programs that may better meet clinical client needs and provide appropriate referrals. • These referrals may include day programs, inpatient psychiatric units, community mental health programs, etc.	• Evidence of ongoing assessment of needs and referrals as appropriate
g. Update treatment plan as needed and at a minimum of every six months	• Evidence of updated treatment plan every six months
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary of discharge in case notes includes: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the mental health treatment provider	• Documentation in client records of discharge summary with relevant signatures • CAREWare service tab and units completed and case notes

MEDICAL NUTRITION THERAPY

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Medical Nutrition Therapy includes: Nutrition assessment and screening, Dietary/nutritional evaluation, Food and/or nutritional supplements per medical provider's recommendation, and Nutrition education and/or counseling. These activities can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

All activities performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Activities not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the HRSA RWHAP. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Ensure that staff and contracted service providers are medical nutrition therapist and are registered dietitians (RD).	• A copy of valid Michigan registration
Service Delivery	
a. Activities pursuant to a medical provider referral	• Copy of referral from a licensed medical provider in the State of Michigan for medical nutrition therapy
b. Assessment of medical nutrition therapy needs and documentation must include: • Nutritional evaluation/ assessment • Nutritional counseling and therapy • Provision of nutritional supplements, as appropriate • HIV and nutritional education materials, etc.	• Documentation of assessment and needs in the client record
c. Coordinated services with client medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers

STANDARD	MEASURE
Service Delivery continued	
d. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
e. Nutritional Care Plan/Service Plan developed collaboratively with the client within 30 days of referral for services. Treatment plan must include: • Description of the need(s) • Action steps/interventions to address the need(s) • Treatment modality • Timeframes to address the need, including recommended number of sessions • Dated signatures of the client and medical, nutritional provider	• Evidence in client records of nutritious Care Plan/Service Plan • Care plan /Service Plan dated and signed
f. Ongoing assessment of the need for nutrition therapy services and complete reassessment at a minimum of every six months	• Evidence of assessment every six months
g. Assess ongoing the need for other nutritional programs that may better meet client nutritional needs and provide appropriate referrals.	• Evidence of ongoing assessment of needs and referrals as appropriate
h. Update nutritional Care Plan/Service Plan as needed and at a minimum of every six months	• Evidence of updated Care Plan/Service Plan every six months
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary of discharge in case notes includes: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the medical nutritional treatment provider	• Documentation in client records of discharge summary with relevant signatures • CAREWare service tab and units completed and case notes

MEDICAL CASE MANAGEMENT including TREATMENT ADHERENCE SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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).

In addition to providing medically oriented activities, 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 Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Key activities include: Initial assessment of service needs, Development of a comprehensive, individualized Care Plan/Service 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/Service Plan, Re-evaluation of the Care Plan/Service Plan at least every six months with adaptations as necessary, Ongoing assessment of the client's and other key family members' needs and personal support systems, Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments, and Client-specific advocacy and/or review of utilization of services. (2013 HRSA/HAB National Monitoring Standards—Part B)

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.

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. The minimum education requirements for medical case managers is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. The requirements for medical case managers supervisor include Registered Nurse's (RN), Bachelor of Social Work (BSW), or other related health and human services degree. *Medical case management supervisors who were hired prior to 2015 may substitute related direct client service experience under the supervision of a human services professional for a period of 5 years of full-time work regardless of academic preparation.*	• A copy of a valid license in the State of Michigan, diploma/credentials • • • If medical case management supervisor is hired prior to 2015 and does not meet the minimum education requirements, Documentation of 5 years of related direct client service experience under supervision
b. Ensure all medical case managers and direct supervisor of a medical case, managers must have completed the Medical Case Management offered by MDHHS within 1 year of hire.	• Training certificates/records for appropriate staff
Service Delivery	
a. Biopsychosocial assessment of needs and documentation of Assessment completed within 30 business days of intake or within 30 days of initiation of the assessment in place of the intake. Assessment should include at a minimum • Assessment of immediate needs • Medical Insurance and ADAP needs • Current HIV and primary medical care needs • RW service category needs	• Evidence of assessment in client records within 30 days • Documentation of assessment in CAREWare under services, units of services and case notes
b. Acuity scale guided by biopsychosocial assessment is utilized to assist in preparing the individualized Care Plan/Service Plan and provides guidance on client contact recommendations	• Evidence of acuity scale
c. Coordinated services with client medical care and support services, including medical providers. • Releases of Information for Medical care providers and Nutritional/Mental Health Providers if applicable	• Evidence in client records of coordination with other service providers • Documentation in client record of referrals to healthcare and supportive services and follow up on referrals given. • Documentation in client record of Releases

STANDARD	MEASURE
Service Delivery continued	
d. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
e. Comprehensive, individualized /Service Plan developed collaboratively with the client within 30 days of biopsychosocial assessment or referral for services. Individualized Care Plan/Service Plan must include: • Description of the need(s) • Action steps/interventions to address the need(s) • Treatment modality • Timeframes to address the need • Dated signatures of the client and medical case manager • Updated at a minimum of every six months	• Evidence in client records of individualized Care Plan/Service Plan • Individualized Care Plan/Service Plan dated and signed • Coordination of services required to implement the Care Plan/Service Plan • Care Plan/Service Plan updated every six months
f. Provide ongoing education to clients on identified needs as well as treatment adherence.	• Evidence of on-going client education and treatment adherence counseling as evident in CAREWare and services delivered and units of service
g. Ongoing assessment of client need and contact with client as needed	• Evidence of on-going communication with the client as evident in CAREWare documentation, services delivered and units of service
h. Assess ongoing the need for services that may better meet clinical client needs and provide appropriate referrals. Evidence of follow through with referrals is required.	• Evidence of ongoing assessment of needs and referrals as appropriate • Evidence of follow through with referral obtainment
i. Update acuity scale and Individualized Care Plan/Service Plan as needed and at a minimum of every six months	• Evidence of updated acuity and Individualized Care Plan/ Service Plan
Transition or Discharge	
a. Clients may be discharged or transitioned into another service category (Non-Medical Case Management). Completion of transition/discharge summary in the client records should occur within five business days but no later than ten business days.	• Evidence in client records of transition or discharge within 5 to 10 days • Documentation in CAREWare in case notes, services delivered and units of services

STANDARD	MEASURE
Service Delivery continued	
b. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary of discharge in case notes includes: • Reasons for transition/discharge • Summary of services provided • Client-centered discharge plan • Dated signatures of the medical case manager • Refer to Universal Standards for consents and other documentation needs	• Documentation in client records of discharge summary with relevant signatures and CAREWare service tab and units completed and case notes • Consents

NON-MEDICAL CASE MANAGEMENT

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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, 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, telehealth, phone contact, and any other forms of communication). NMCM does not involve coordination and follow-up of medical treatments. (2013 HRSA/HAB National Monitoring Standards—Part B)

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.

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B)

STANDARD	MEASURE
Staff Requirements	
a. The minimum education requirements for non-medical case managers are a high school diploma or GED The requirements for non-medical case managers supervisor include Registered Nurse's (RN), Bachelor of Social Work (BSW), or other related health and human services degree. *Non-Medical case management supervisors who were hired prior to 2015 may substitute related direct client service experience under the supervision of a human services professional for a period of 5 years of full-time work regardless of academic preparation.*	• A copy of a valid diploma or GED • A copy of a valid license in the State of Michigan, diploma/credentials for supervisors • *If non-medical case management supervisor is hired prior to 2015 and does not meet the minimum education requirements, Documentation of 5 years of related direct client service experience under supervision*
b. Ensure all non-medical case managers and direct supervisor of non-medical case managers must have completed the Medical Case Management offered by MDHHS within one year of hire.	• Training certificates/records for appropriate staff
Service Delivery	
a. Biopsychosocial assessment of needs and documentation of Assessment completed within 30 business days of intake or within 30 days of initiation of the assessment as the intake. Assessment should include at a minimum: • Assessment of immediate needs • Medical Insurance and ADAP needs • Current HIV and primary medical care needs • RW service category needs	• Evidence of assessment in client records within 30 days • Documentation of assessment in CAREWare under services units of services and case notes
b. Acuity scale guided by biopsychosocial assessment is utilized to assist in guidance into medical or non-medical case management services as well as assist in preparing the individualized care plan/Service Plan	• Evidence of acuity scale
c. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes

STANDARD	MEASURE
Service Delivery continued	
d. Comprehensive, individualized Care Plan/Service Plan developed collaboratively with the client within 30 days of biopsychosocial assessment or referral for services. Individualized Care Plan/Service Plan must include: • Description of the need(s) • Action steps/interventions to address the need(s) • Treatment modality • Timeframes to address the need • Dated signatures of the client and non-medical case manager or captured within CAREWare case notes • Referrals must be followed up within 30 days	• Evidence in client records of individualized Care Plan/Service Plan • Individualized Care Plan/Service Plan dated and signed or evidence in CAREWare case notes • Coordination of services required to implement the Care Plan /Service Plan • Evidence up updated Care Plan/Service Plan every six months in CAREWare case notes
e. Provide ongoing education to clients on identified needs as well as treatment adherence as needed.	• Evidence of on-going client education and treatment adherence counseling as evident in CAREWare and services delivered and units of service
f. Ongoing assessment of client need and contact with client as identified through initial acuity.	• Evidence of on-going communication with the client as evident in CAREWare documentation, services delivered and units of service
g. Assess ongoing the need for services that may better meet client clinical needs and provide appropriate referrals. Evidence of follow through with referrals is required.	• Evidence of ongoing assessment of needs and referrals as appropriate • Evidence of follow through with referral obtainment
h. Update Individualized care plan /Service Plan as needed and at a minimum of every six months.	• Evidence of updated individualized Care Plan/Service Plan or CAREWare documentation

STANDARD	MEASURE
Transition or Discharge	
a. Clients may be discharged or transitioned into another service category (Medical Case Management). Completion of transition/discharge summary in the client records should occur within five business days but no later than ten business days.	• Evidence in client records of transition or discharge within 5 to 10 days • Documentation in CAREWare in case notes, services delivered and units of services
b. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary of discharge in case notes includes: • Reasons for transition/discharge • Summary of services provided • Client-centered discharge plan • Referrals provided • Dated signatures of the non-medical case manager, if only utilizing CAREWare, documentation of the necessary elements above in the case notes • Refer to Universal Standards for consents and other documentation needs	• Documentation in client records of discharge summary with relevant signatures or evidence in CAREWare case notes • CAREWare service tab and units completed and case notes • Consents

EMERGENCY FINANCIAL ASSISTANCE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. All EFA requests $1,000 or greater must receive prior approval from MDHHS before payment can be made. Send requests and supporting documents to: MDHHS-HIVSTDoperations@michigan.gov.EFA must occur as a direct payment to an agency or through a voucher program. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Eligibility Requirements	
a. Established eligibility criteria for the provision of emergency financial assistance that includes, at minimum: • Income limits • Amount limits • Requirements to access other resources before Ryan White funds • Documentation of need and why it is an emergency • Documentation verifying that consumer is in HIV medical care	• Evidence of minimum criteria for EFA • Documentation of client EFA needs, budgeting education and evidence of payor of last resort • Documentation in CAREWare service tab and units completed and case notes
b. Emergency financial assistance for is limited to one time or short term to the client with urgent needs for essential items or services. Ryan White funds are used for EFA only as a last resort. Payments $1,000 and over need prior approval from MDHHS before payment can be made, send request and all supporting documentation to: MDHHS-HIVSTDoperations@michigan.gov. Record and track use of EFA funds under each discrete service category as required by the Ryan White Service (*Please see completed list of HRSA unallowable costs in the appendix)*	• Policy and Procedures for the provision of EFA • Documentation in client records of emergency or urgent needs • Documentation of dollar amounts in CAREWare

c. Ensure that clients are in care or actively taking steps to engage in HIV medical care. If a client needs assistance accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days

FOOD BANK/HOME-DELIVERED MEALS

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, nutritional supplements, or a voucher program to purchase food. This also includes the 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. Appropriate licensure/certification for food banks and home-delivered meals where required under State or local regulations. Unallowable costs include household appliances, pet foods, and other non-essential products (2013 HRSA/HAB National Monitoring Standards—Part B) (*Please see completed list of HRSA unallowable costs in the appendix).*

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Eligibility Requirements	
a. Established eligibility criteria for the provision of food bank/home-delivered meals that includes, at minimum: • Community Resource availability • Requirements to access other resources before Ryan White funds (denials from other community resources) • Documentation of need • Documentation verifying that the client is in HIV medical care	• Evidence of minimum criteria for food bank/home-delivered meals • Documentation of client food bank/home-delivered meals needs, budgeting education and evidence of payor of last resort • Documentation in CAREWare service tab and units completed and case notes
b. Ryan White funds are used for food bank/home delivered meals only as a last resort. Record and track use of food bank/home-delivered meal funds food bank/home-delivered meals service category as required by the Ryan White Service.	• Policy and Procedures for the provision of food bank/home-delivered meals • Documentation in consumer records of food bank/home-delivered meals or needs • Documentation of dollar amounts in CAREWare
c. Ensure that clients are in care or actively taking steps to engage in HIV medical care. If a client needs assistance accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days
d. If providing on-site food bank/home-delivered meals, facilities must maintain licenses and permits required by Michigan law to operate the food bank/ home-delivered meals services	• A copy of a valid license in the State of Michigan and displayed at the site

HOUSING SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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 achieve or maintain access to medical care. Activities within the Housing category must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. The housing may provide some type of core medical (e.g., mental health services) or support services (e.g., residential substance use disorder 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.

HRSA RWHAP recipients and sub-recipients 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 sub-recipients, along with local decision-making planning bodies, are strongly encouraged to institute duration limits to housing activities. HRSA HAB recommends recipients and sub-recipients 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. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Eligibility Requirements	
a. Established eligibility criteria for the provision of housing assistance that includes, at minimum: • Assessment of client need • Use of funds and time limits • Maximum amount per contract year and re-application periods • Fair Market Rent (FMR), RW will not pay more than FMR • Emergency housing, validating housing conditions • Short term lodging and that Ryan White funds will NOT cover all incidental charges such as food and beverages, telephone, liquor, tobacco products, movies, and entertainment. • Transitional housing is limited to twenty-four (24) months; with supervisor approval, this may be extended • Requirements to access other resources before Ryan White funds • Documentation of need and why it is an emergency • Documentation verifying that consumer is in HIV medical care	• Evidence of minimum criteria for Housing • Documentation of client housing needs, budgeting education and evidence of payor of last resort • Documentation in CAREWare service tab and units completed and case notes
b. Funds paid for housing are substantially different from Emergency Financial Assistance in that housing funds should be used to secure long-term, stable housing. Ryan White funds are used only as a last resort. Record and track use of housing funds under housing service category as required by the Ryan White Service	• Policy and Procedures for the provision of housing • Documentation in client records of emergency or urgent needs • Documentation of dollar amounts in CAREWare
c. Payments are made out to a vendor. No payment can be made directly to clients, family, or household members.	• Copy of invoice/bill paid • Copy of check for payment • Copy of documentation of application for other assistance, if applicable • Documentation of need and attempts at locating other available resources
d. Ensure that clients are in care or actively taking steps to engage in HIV medical care. If consumers need assistance accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days

OTHER PROFESSIONAL SERVICES (Previous LEGAL and PERMANENCY PLANNING)

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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. Such services may include: Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including: Assistance with public benefits such as Social Security Disability Insurance (SSDI), Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP, and Preparation of: Healthcare power of attorney, Durable powers of attorney, and Living wills.

Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including: Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney, Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

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

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Eligibility Requirements	
a. Established eligibility criteria for the provision of professional services that include, at minimum: • Assessment of client need • Use of funds and time limits • Maximum amount per contract year • Requirements to access other resources before Ryan White funds • Documentation of need and why it is a need • Documentation verifying that the client is in HIV medical care	• Evidence of minimum criteria for professional services • Documentation of client professional service needs, budgeting education and evidence of payor of last resort • Documentation in CAREWare service tab and units completed and case notes
b. Ryan White funds are used for professional services only as a last resort. Record and track use of professional service category in CAREWare as required by the Ryan White Service.	• Policy and Procedures for the provision of professional services • Documentation in client records of emergency or urgent needs • Documentation of dollar amounts in CAREWare
c. Ensure that professional services or consulting services are rendered by those certified or licensed to provide such service.	• Copy of valid Michigan license or certification
d. Payments are made out to a vendor. No payment can be made directly to clients, family, or household members.	• Copy of invoice/bill paid • Copy of check for payment • Copy of documentation of application for other assistance, if applicable • Documentation of need and attempts at locating other available resources
e. Inform clients and work with contracted service providers to decide the objective of the representation, make decisions regarding the services and to achieve goals in a timely fashion	• Documentation in CAREWare, client records of progress notes that correspond to the units of service
f. Ensure that clients are in care or actively taking steps to engage in HIV medical care. If the client needs assistance accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days

MEDICAL TRANSPORTATION

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

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), and Voucher or token systems. (2013 HRSA/HAB National Monitoring Standards—Part B)

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 a privately-owned vehicle, any other expenses associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees (*Please see completed list of HRSA unallowable costs in the appendix).*

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Eligibility Requirements	
a. Established eligibility criteria for the provision of medical transportation that includes, at minimum: • Assessment of client need • Eligibility for other transportation services such as through Medicaid • Use of funds • Requirements to access additional resources before Ryan White funds • Documentation of need and why it is a need • Documentation verifying that consumer is in HIV medical care	• Evidence of minimum criteria for medical transportation • Documentation of client medical transportation needs, budgeting education and evidence of payor of last resort • Documentation in CAREWare service tab and units completed and case notes
b. Ryan White funds are used as a last resort. Record and track use of medical transportation funds under the service category in CAREWare as required by Ryan White Service.	• Policy and Procedures for the provision of medical transportation • Documentation in consumer records of emergency or urgent needs • Documentation of dollar amounts in CAREWare
c. Payments are made out to a vendor. No payment may be made directly to clients, family, or household members. If the provision of medical transportation is providing bus tokens or gas cards, the client may directly receive, no cash payments are made directly to clients, family, or household members.	• Copy of invoice/bill paid • Copy of check for payment • Copy of documentation of application for other assistance, if applicable • Documentation of need and attempts at locating other available resources
d. Client must use medical Transportation services to access HIV-related health and support services, which includes getting to and from appointments for: • Medical care (HIV and Primary) • Mental health treatment • Substance abuse treatment • Dental care • Vision care • Department of Human Services • Social Security Administration • Support Groups • Food Sources • Housing needs	• Evidence of transportation reason in relation to the access to specific HIV related health and support services

STANDARD	MEASURE
Eligibility Requirements continued	
e. Required record keeping, to track services provided.	• Trip origin and destination • Trip cost • Method used for transportation • Confirmation of medical appointment kept
f. Ensure that consumers are in care or actively taking steps to engage in HIV medical care. If consumers need assistance accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days
Service Delivery (for direct transportation providers)	
a. Drivers must have, at minimum, a valid chauffer's license. The provider must verify the driving records of all drivers once a year.	• Copy of current Chauffeur's License • Documentation of annual review of records
b. All vehicles used in medical transportation must have appropriate, updated registration, and insurances.	• Copy of vehicle registration and insurance
c. All vehicles used in medical transportation must have regular maintenance and inspections according to the vehicle's maintenance schedule.	• Policies and procedures for routine service and inspection • Documentation of vehicle maintenance history
d. All vehicles used in medical transportation must have standard safety equipment in compliance with federal and state laws.	• Policies and procedures on driver and passenger safety
e. The provider must ensure that medical transportation services are available to those with disabilities who may require an assistive device.	• Site visit observation that confirms the presence of assistive equipment
f. The provider must offer curb to curb transportation services to consumers with disabilities.	• Documentation that proper maintenance of transport mechanisms is available
g. The provider must ensure that medical transportation services are available for consumers with needs outside of normal business hours.	• Policies and procedures • Notification to consumer of limitation of drivers on file • Policies and procedures for accommodating consumers outside normal business hours

PSYCHOSOCIAL SUPPORT

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include: Bereavement counseling, Child abuse, and neglect counseling, HIV support groups, Nutrition counseling provided by a non-registered dietitian, and Pastoral care/counseling services.

Funds under this service category may not be used to provide nutritional supplements

HRSA RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. HRSA RWHAP Funds may not be used for social/recreational activities or to pay for a client's gym membership. (2013 HRSA/HAB National Monitoring Standards—Part B)

CAREWare Data Definitions

Refer to the most recent *MDHHS Ryan White Parts B and D Standardized CAREWare Service Categories and Sub-services* for more information on sub-service categories and units of service for CAREWare data entry (Appendix A).

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Service Delivery	
a. Documentation of services provided under service psychosocial support services.	• Evidence of psychosocial support (sign-in-sheets, materials given out, guest speaker information) for group sessions • Documentation in CAREWare in service tab, units completed and case notes
b. Documentation of topics or interventions used during psychosocial support services.	• List of topics covered • Documentation in client records of individual counseling session topics/interventions
c. Evaluate on an annual basis the services and topics covered to ensure they meet consumer needs.	• Client satisfaction survey • Evidence of modification to service delivery based on client feedback
Pastoral Care/Counseling	
a. Ensure pastoral counseling is eligible to clients regardless of religious denominational affiliation	• Evidence of pastoral counseling eligibility • Documentation in CAREWare, client records of progress notes that correspond to the units of service

HOME HEALTH CARE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include: Administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment, and parenteral feeding), Preventive and specialty care, Wound care, Routine diagnostics testing administered in the home, and Other medical therapies.

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

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of home health care services. Standards can be found at: State of Michigan Home Health Agency Provider Standards	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of home health care services. The following are not considered an allowable location: • Nursing facilities • Inpatient mental health/substance abuse treatment facilities • Nursing homes • Long-term care facilities	• Site visit observation • Site visit description

STANDARD	MEASURE
Service Delivery	
a. Medical team written referral Care Plan/Service Plan established to meet the client needs related to HIV.	• Documentation from the medical provider/team of the need for home health care services.
b. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services	• Documentation of location of services • Documentation of treatment modalities in the client record
c. Assessment of needs	• Documentation of needs in client record
d. Care Plan/Service Plan of needs which includes: • A specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and home health care provider	• Referral for home health care services • Documentation of Care Plan/Service Plan in client records
e. Care Plan/Service Plan updated on an on-going basis and at a minimum of every six months	• Updated Care Plan/Service Plan in client records
Reauthorization of Services	
a. Re-authorized services per the following: • Services (e.g., home health nurse and aide) must be reauthorized every 120 days *Reauthorization decisions must be made in conjunction with the nurse, physician, and other staff (e.g., medical case manager) as appropriate*	• Evidence in client records of reauthorization
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the home health care provider	• Evidence in client records and CAREWare of services, units and case notes

HOSPICE SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are: Mental health counseling, Nursing care, Palliative therapeutics, Physician services, and Room and board.

Hospice Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes. To meet the need for Hospice Services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of Hospice Services. Laws and standards can be found at: Michigan Hospice Care Laws	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of hospice care services. The following are not considered an allowable location: • Skilled Nursing facilities • Nursing homes	• Site visit observation • Site visit description

STANDARD	MEASURE
Service Delivery	
a. Medical team written referral Care Plan/Service Plan established to meet the client needs related to HIV	• Documentation from the medical provider/team of the need for Hospice Services
b. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of Hospice services	• Documentation of location of services • Documentation of treatment modalities in a client record
c. A physician must certify that the client is terminally ill and has a defined life expectancy as established by the Michigan Standards. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective Michigan Medicaid programs.	• Documentation of terminal stages of illness in the client record
d. Care Plan /Service Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and home health care provider	• Referral for Hospice Services • Documentation of Care Plan/Service Plan in client records
e. Care Plan /Service Plan updated on on-going basis and at a minimum of every six months	• Updated Care Plan/Service Plan in client records
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the hospice provider	• Evidence in client records and CAREWare of services, units and case notes

SUBSTANCE ABUSE OUTPATIENT CARE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Activities under Substance Abuse Outpatient 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, and Relapse prevention.

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.

Written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists; services provided must include a treatment plan that calls only for allowable activities and includes: the quantity, frequency, and modality of the treatment provided; the date treatment begins and ends; regular monitoring and assessment of client progress; the signature of the individual providing the service and/or the supervisor as applicable.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of substance abuse outpatient care services. Information can be found at: MDHHS Substance Abuse Treatment Section	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the types of activities allowable under the RW standards. The following are allowable: • Screening • Assessment • Diagnosis and/or Treatment of substance use disorder, including: • Pretreatment/recovery readiness programs • Harm reduction • Behavioral health counseling associated with a substance use disorder • Outpatient drug-free treatment and counseling • Medication-assisted therapy • Neuro-psychiatric pharmaceuticals • Relapse prevention	• Site visit observation • Site visit description
Service Delivery	
a. Medical team written referral Care Plan/Service Planestablished to meet the client needs related to substance use and HIV	• Documentation from the medical provider/team of the need for substance abuse services
b. Ensure that the services are provided in accordance with allowable modalities under the definition of substance abuse services.	• Documentation of treatment modalities in the client record
c. Assessment of needs to include • Substance abuse screening • Diagnosis • Pre-treatment/recovery readiness • Harm reduction • Behavioral health counseling associated with a substance use disorder • Medication	• Documentation of needs in the client record

STANDARD	MEASURE
Service Delivery continued	
d. Care Plan/Service Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and substance abuse provider	• Referral for substance abuse services • Documentation of Care Plan/Service Plan in client records
e. Care Plan/Service Plan updated on on-going basis and at a minimum of every six months	• Updated Care Plan/Service Plan in client records
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided.	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the substance abuse provider	• Evidence in client records and CAREWare of services, units and case notes

CHILD CARE SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH who are HRSA RWHAP-eligible clients to enable those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions. Allowable use of funds includes: A licensed or registered child care provider to deliver intermittent care or informal child care provided by a neighbor, family member, or another person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted. Such arrangements may also raise liability issues for the funding source, which should be carefully weighed in the decision process.

Such allocations to be limited and carefully monitored to assure compliance with the prohibition on direct payments to eligible individuals; assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White program. May include recreational and social activities for the child if provided in a licensed or certified provider setting, including drop-in centers in primary care or satellite facilities. Excludes the use of funds for off-premise social/recreational activities.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Childcare services must meet the provided by licensing/credentialing childcare center by the State of Michigan. Information can be found at: Licensed Child Care Centers and Homes	• A copy of valid Michigan license or proper certification
b. Ensure services are being provided in accordance with the types of activities allowable under the RW standards enabling the PLWH to attend medical appointments, related appointments, related meetings, or training.	• Evidence of appointment for HIV care and other activities associated with HIV related services
Service Delivery	
a. Documentation of medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions	• Documentation of the need for childcare services in CAREWare
b. Ensure that clients are in care or actively taking steps to engage in HIV medical care. If a client needs assistance with accessing HIV medical care, referrals must be provided.	• Documentation in client record of HIV medical care and/or referrals for care • Follow up on referrals within 30 days
c. Assessment of needs to include: • Screening needs for childcare services • Childcare conflicts with care appointments	• Documentation of assessment in client record
d. Payments are made out to a vendor. No payment may be made directly to clients, family, or household members.	• Copy of invoice/bill paid • Copy of check for payment • Copy of documentation of application for other assistance, if applicable • Documentation of need and attempts at locating other available resources

HEALTH EDUCATION/ RISK REDUCTION

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include: Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention, education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage), health literacy, and treatment adherence education.

Health Education/Risk Reduction services cannot be delivered anonymously.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Ensure that staff and contracted service providers receive HIV counseling and testing training. Continuing education in HIV/AIDS treatment or care annually Staff must complete the following: • Motivational Interviewing • Case Management Training • Counseling Testing and Referral (CTR) Training <u>Optional:</u> Choosing Life: Empowerment, Action Results (CLEAR) Antiretroviral Treatment Access Study (ARTAS)	• A copy of certification • Documentation of continuing education in personnel file

Service Delivery	
a. Referral for Health Education Risk Reduction is documented prior to initiation of the service	• Documentation of referral for Health Education Risk Reduction Services is present in the client's record/CAREWare
b. Offer ongoing education to client on the identified health education, risk reduction, and health literacy needs At minimum, the provider must ensure that client have knowledge of: • HIV transmission and how to reduce the risk of HIV transmission to others • Information about available medical and psychosocial support services • Education on methods of HIV transmission and how to reduce the risk of transmission • Counseling on how to improve their health status and reduce the risk of transmission to others • Disclosure concerns • Education on health care coverage options • Medication/Treatment Adherence	• Documentation in client record/CAREWare of plans for education sessions that include, at minimum, the identified topics
c. Refer client to other services as appropriate, e.g. mental health, substance abuse treatment	• Documentation of referrals in client record/CAREWare
d. Document all services provided into CAREWare under service tab as well as case notes that corresponds with the services and units provided	• Evidence in client record/CAREWare of; services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary of discharge in case notes includes: • Date services began • Special client needs • Services needed/actions taken, if applicable • Date of discharge • Reason(s) for discharge (see RW Service Standards regarding Discharge) • Referrals made at time of discharge, if applicable	• Documentation of discharge plan and summary in client record/CAREware with clear rationale for discharge within 30 days of discharge • CAREWare service tab and units completed and case notes

LINGUISTIC SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Linguistic Services include interpretation and translation activities, both oral and written, to eligible clients. Qualified linguistic services providers must provide these activities as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of HRSA RWHAP-eligible services.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Ensure that staff and contracted service providers are qualified as linguistic service providers. Interpreter Directory, Department of Licensing & Regulatory Affairs	• A copy of certification/education to demonstrate linguistic services provider
Service Delivery	
a. Services may be delivered through the following: • Bilingual staff • Contract interpreters • Telephone interpreter Services	• Evidence of interpretation services in client records as needed • Policy and procedures
b. Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and the Michigan Department of Civil Rights. Michigan Department of Civil Rights, Division on Deaf, Deafblind and Hard of Hearing	• Documentation of service compliance
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes

OUTREACH

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status or who know their status but are not currently in care. As such, Outreach Services provide the following activities: Identification of people who do not know their HIV status and/or Linkage or re-engagement of PLWH who know their status into HRSA RWHAP services, including the provision of information about health care coverage options.

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

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

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV, or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and sub-recipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding.

Performance Measures

Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Outreach staff have a clear understanding of their job description and responsibilities.	• A written job description that includes roles and responsibilities
b. Outreach staff have appropriate skills, relevant experience, cultural and linguistic competency (CLAS) knowledge about HIV/AIDS, HIV outreach, and available health and social services related resources.	• Training records of staff related to CLAS standards and outreach skills
Service Delivery	
a. Agency demonstrates the ability to effectively reach the desired target population.	• Agency client data report consistent with funding requirements
b. Agency demonstrates input from clients and agencies in outreach delivery.	• Client satisfaction survey
c. Staff includes the provision of the following three activities: • Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services • Provision of additional information and education on health care coverage options • Reengagement of people who know their status into Outpatient/ Ambulatory Health Services	• Agency client data reports consistent with funding requirements
d. Outreach programs must be: • Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior • Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of the effectiveness of the program • Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort • Targeted to populations known, through local epidemiologic data or review of service utilization data, to be at disproportionate risk for HIV infection	• Agency client data reports consistent with funding requirements

REFERRAL FOR HEALTH CARE AND SUPPORT SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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

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

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

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff Requirements	
a. Staff and agencies build and maintain effective relationships with community partners, and, whenever possible, sign a Memorandum of Agreement (MOA) between the implementing agency and community partners to facilitate the referral process. Providers will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	• Evidence of MOA or MOU with service providers on file.
Service Delivery	
a. Staff shall ensure that Referrals for Health Care and Support Services assist clients through the health care system and HIV Continuum of Care. Staff shall ensure Referrals for Health Care and Support Services focus on assisting client's with referrals critical to achieving optimal health and well-being. Staff shall ensure that clients are accessing needed referrals and services, and following through with their referral plan.	• Evidence of referrals documented as a Case Note in CAREWare, and or in the cleint's file with corresponding service unit. • Documentation of follow-up on referrals and outcomes as a Case Note in CAREWare and or in the client's file.

a. Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. Staff will explore the following as possible options for clients, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/Marketplace) • Social Security Programs (SSI, SSDI, SDI) • Veteran's Administration Benefits (VA) • Other public/private benefits programs • Other professional services Staff shall work with the client to identify barriers clients may have that impede access	• Evidence of eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record • Evidence of release of information is present in the client's file. • Documentation of barriers clients may have that impede access barriers to referrals and facilitate access to referrals and actions taken to resolve them as case notes in CAREWare and or in the client's file.

REHABILITATION SERVICES

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

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

Allowable activities under this category include physical, occupational, speech, and vocational therapy.

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

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE

Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of rehabilitation services.	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of rehabilitation services. The following are not considered an allowable location: • Inpatient hospital facilities • Nursing homes • Long-term care facilities	• Site visit observation • Site visit description
Service Delivery	
a. Medical team written referral Care Plan/Service Plan established to meet the client's needs related to HIV. Funds may be used for physical and occupational therapy, speech pathology services, and low vision training to improve or maintain a client's quality of life. • Physical therapy helps to maximize the client's capabilities. Typical programs may include: o Therapeutic exercise o Strength and mobility training o Gait and balance training o Muscle re-education o Innovative treatment modalities such as heat, cold, and electrical stimulation • By concentrating on daily living activities, skilled occupational therapists help clients adjust to everyday environments. Therapies may include: o Education and training in daily living skills, including eating, bathing, dressing, and grooming o Sensory-motor skills re-training o Strength and range of motion training o Cognitive integration techniques o Selection and use of adaptive equipment o Design, fabrication, and application of orthoses (splints) • Speech and language pathology therapies maintain the ability to communicate. Therapies may include: o Exercises to stimulate receptive, integrative, and expressive processes o Sensory-motor activities to stimulate chewing, swallowing, articulatory, and voice processes	• Documentation from the medical provider/team of the need for home health care services and types of services to be provided

○ Selection and training in the use of no-oral communications aids, including augmentative systems ○ Specialized swallowing therapy ○ Cognitive skills training ○ Compensatory swallowing techniques • Low vision training teaches the client how to use their remaining vision more effectively. Services may include rehabilitation training for: ○ Reading ○ Writing ○ Shopping ○ Cooking ○ Lighting ○ Glare control	
b. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of rehabilitation services	• Documentation of location of services • Documentation of treatment modalities in the client record
c. Assessment of needs	• Documentation of needs in client record
STANDARD	**MEASURE**
Service Deliver continued	
d. Care Plan/Service Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and rehabilitation provider	• Referral for rehabilitation services • Documentation of Care Plan/Service Plan in client records
e. Care Plan/Service Plan updated on on-going basis and at a minimum of every six months.	• Updated Care Plan/Service Plan in client records
Service Coordination	
c. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
d. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes

Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the rehabilitation provider	• Evidence in client records and CAREWare of services, units and case notes

RESPITE CARE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Respite Care is the provision of periodic respite care in the community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-to-day care.

Recreational and social activities are allowable program activities as part of a Respite Care provided in a licensed or certified provider setting, including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in consideration of this expenditure. Direct cash payments to clients are not permitted.

Funds may not be used for off-premise social/recreational activities or to pay for a client's gym membership.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. A caregiver is defined as someone who either cares for an HIV-positive individual, or is an HIV-positive individual who is responsible for taking care of children.	• A clear assessment of qualifications of client's support network provider defined who is the respite caregiver

b. Ensure services are being provided in accordance with the type of locations allowable under the definition of respite care services. The following are allowable locations: • Community-based setting • Home-based • Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities Funds are **NOT** to be used for: • OFF premise Social/recreational activities • Gym memberships	• Site visit observation • Site visit description • If activities are provided at a licensed setting, provide Michigan license
Service Delivery	
a. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of Respite services	• Documentation of location of services • Documentation of treatment modalities in the client record
b. Assessment of needs, which includes the qualifications of the client's personal support network provider.	• Documentation of needs in the client record
c. In collaboration with the client and client's family, a plan of care will be developed within ten (10) business days of a brief initial assessment. The plan of care should include: • Specific need for services • Dates, times and location of services • Time frame to address needs • Objectives and action steps/interventions to meet needs • Dated signatures of the client and respite provider	• Documentation of Care Plan/Service Plan in client records
d. Documentation of services and dates	• Sign-in sheet documenting attendance in a facility or documentation of informal personal support network provider attendance in the home • Objective should be listed at the top of the sign-in sheet or documentation for

	reimbursement by the informal personal support network provider
e. Care plan /Service Plan updated on on-going basis and at a minimum of every six months	• Updated Care Plan/Service Plan in client records
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided	• Evidence in client records and CAREWare of services, units and case notes
c. Referrals: If the needs of the client are beyond the scope of the services provided by the agency or clients informal support network, an appropriate referral to another level ofcare is made. Documentation of referral and outcome of the referral is present in the client's primary record.	• Documented referrals for services beyond the scope of the respite care provider in the client's primary client record
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the Respite provider	• Evidence in client records and CAREWare of services, units and case notes

SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Description

Substance Abuse Services (residential) activities are those provided for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. Activities provided under the Substance Abuse Services (residential) service category include: Pretreatment/recovery readiness programs, Harm reduction, Behavioral health counseling associated with substance use disorder, Medication-assisted therapy, Neuro-psychiatric pharmaceuticals, Relapse prevention, and Detoxification if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital).

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

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

HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

Performance Measures

Refer to the most recent *MDHHS Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE

Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of residential Substance Abuse services.	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of residential Substance Abuse services.	• Site visit observation • Site visit description • If residential substance use treatment services are provided in a facility that primarily provides inpatient medical or psychiatric care, the component providing the substance use treatment must be separately licensed for that purpose
Service Delivery	
a. Medical team written referral from the clinical provider as part of a substance use disorder treatment program established to meet the client needs	• Documentation from the medical provider/team of the need for residential substance services
b. Ensure that the services are provided in accordance with allowable modalities and locations under the definition of residential substance abuse services	• Documentation of location of services • Documentation of treatment modalities in the client record
c. Providers must provide the following service components: • Intake • Individual counseling or Group counseling • Patient education • Family therapy as needed • Medication services • Collaborative services • Crisis intervention services • Treatment planning • Transportation Services as needed • Discharge services	• Documentation of needs in the client record • A comprehensive written program service delivery protocol outlining how staff will deliver all service components
d. The appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations, when deemed necessary.	• Medical record of physical examinations and medical evaluation by a Michigan licensed medical provider
STANDARD	**MEASURE**

Service Delivery continued	
e. Care Plan/Service Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and substance abuse provider	• Referral for substance abuse services • Documentation of Care Plan/Service Plan in client records
f. Care Plan/Service Plan updated on on-going basis and at a minimum of every six months.	• Updated Care Plan/Service Plan in client records
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided.	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the substance abuse provider	• Evidence in client records and CAREWare of services, units and case notes

ORAL HEALTH CARE

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

Service Definition

Oral Health Care Description: 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 licensed dental assistants.

Performance Measures

Refer to the most recent *MDCH Summary of Performance Measures* (Appendix B).

STANDARD	MEASURE
Staff and Site Requirements	
a. Agencies and Staff must meet the minimum licensing/credentialing requirement of the State of Michigan for the provision of Oral Health Care services.	• A copy of valid Michigan license or proper credentialing
b. Ensure services are being provided in accordance with the type of locations allowable under the definition of Oral Health Care services.	• Site visit observation • Site visit description • Policy and Procedures
Service Delivery	
a. Medical team conducts intake for oral care needs that includes: • informing the client of services available and what the client can expect when enrolling in services, including methods and scope of service delivery at a particular facility • Client information on eligibility and treatment requirements (such as current lab values) • Provide client with referral information to other services, as appropriate	• Documentation from the medical provider/team of the need for oral health services
b. Treatment Plan of needs which includes: • Specific need for services • Dates, times and location of services • time frame to address needs • Treatment modality • Action steps/interventions to meet needs • Dated signatures of the client and oral health provider	• Referral for oral health services • Documentation of treatment plan in client records
c. Treatment plan updated on on-going basis and at a minimum of every six months.	• Updated treatment plan in client records

STANDARD	MEASURE
Service Coordination	
a. Coordinated services with client's medical care and support services, including medical case management.	• Evidence in client records of coordination with other service providers
b. Document all services provided into CAREWare under service tab as well as case notes that correspond with the services and units provided.	• Evidence in client records and CAREWare of services, units and case notes
Discharge	
a. Complete discharge summary that indicates services complete in CAREWare case notes, service tab, and unit of services. Summary to include: • Summary of needs at admission • Summary of services provided • Goals completed during treatment • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated signatures of the oral health provider	• Evidence in client records and CAREWare of services, units and case notes

APPENDIX

UNALLOWABLE COST

IMPORTANT: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards--Universal, HRSA/HAB National Monitoring Standards--Fiscal Part B, HRSA/HAB National Monitoring Standards--Part B, and the Universal Standards outlined in this document.

HRSA RWHAP funds may not be used to make cash payments to intended clients of HRSA RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for HRSA RWHAP core medical and support services. Where a direct provision of the service is not possible or effective, store cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

HRSA RWHAP recipients are advised to administer voucher and store card programs in a manner which assures that vouchers and store cards cannot be exchanged for cash or used for anything other than the allowable goods or services and that systems are in place to account for disbursed vouchers and store cards

HRSA Unallowable Costs:
• Off-premise social or recreational activities (movies, vacations, gym memberships, parties, retreats) • Medical Marijuana • Purchase or improve land or permanently improve buildings • Direct cash payments or cash reimbursements to clients • Clinical Trials: Funds may not be used to support the costs of operating clinical trials of investigational agents or treatments (to include administrative management or medical monitoring of patients) • Clothing: Purchase of clothing • Employment Services: Support employment, vocational rehabilitation, or employment-readiness services. • Funerals: Funeral, burial, cremation or related expenses • Household Appliances • Mortgages: Payment of private mortgages • Needle Exchange: Syringe exchange programs, Materials, designed to promote or encourage, directly, intravenous drug use • International travel • The purchase or improvement of land • The purchase, construction, or permanent improvement of any building or other facility • Pets: Pet food or products • Taxes: Paying local or state personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied)

- Vehicle Maintenance: Direct maintenance expense (tires, repairs, etc.) of a privately-owned vehicle or any additional costs associated with a privately-owned vehicle, such as a lease, loan payments, insurance, license or registration fees
- Water Filtration: Installation of permanent systems of filtration of all water entering a private residence (water filtration/ purification systems are allowable in communities where issues of water safety exist)
- Pre-Exposure Prophylaxis (PrEP)
- Non-occupational Post-Exposure Prophylaxis (nPEP)

General-use prepaid cards are considered “cash equivalent” and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store cards, and therefore are unallowable.

HRSA RWHAP recipients are advised to administer voucher and store card programs in a manner which assures that vouchers and store cards **cannot** be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store cards.

For additional information, please see HRSA/HAB National Monitoring Standards and HRSA/HAB Policy Notice 16-02:

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