Policies & Procedures Manual

Ryan White Part A
Cleveland TGA

CCBH CUYAHOGA COUNTY BOARD OF HEALTH

Your Trusted Source For Public Health Information

CONTENTS

Introduction

Statement of Purpose

The Cuyahoga County Board of Health has developed this manual as a guide for the effective implementation of the Greater Cleveland Transitional Grant Area (TGA) Ryan White Part A Program grant management and service delivery business processes. This manual should be used as a point of reference for Ryan White Part A Program Recipient staff and Part A-funded contractors and service providers. The manual contains a broad range of information to assist Recipient staff, contractors and service providers in day-to-day management of program and reporting requirements.

Application and Use of this Manual

This policies and procedures manual has been designed as a resource tool for the administration and implementation of the Ryan White Part A Program. Each policy and/or procedure contains the following:

- **Policy Statement**: provides a background, description and intent of the policy
- **Procedures**: action items required for the contractor or service provider to be compliant with established policy
- **Authority/Oversight**: origin of the policy and the entity that provides oversight for implementation of the policy/procedure
- **Published Date**: the effective date of the policy/procedure, including any revision date(s)

The development of the Ryan White Part A policies and procedures is an open and ongoing process requiring updates and/or changes that may result from legislative, administrative, fiscal, programmatic and/or continuous quality improvement changes. The administrative policies are reviewed by the Recipient periodically to ensure continued accuracy and relevance. Any changes are reflected in the Manual Review Tracker. It is expected that updated/revised policies and procedures will be shared with appropriate staff responsible for implementing the policy/procedure. Questions regarding the implementation of the policies and procedures in this manual, as well as any exemption sought to these policies/procedures should be directed to the Ryan White Part A Program Supervisor.

Definitions

Policies: the rules or guidelines by which an agency operates. They may be general or specific but always reflect the philosophy, mission and goals of the agency. Policies are generally approved by the agency's leadership and implemented by management. They define operations such as staff organization, services, business hours, and conditions for business transactions. Policies may, among other functions, set criteria for eligibility to receive services, establish the agency's commitment to confidentiality of protected or sensitive information, and/or outline processes for managing and monitoring of contracts.

Procedures: the methods or sets of instructions by which policies are carried out. Procedures provide specific steps for accomplishing required tasks, handling information, and making service delivery decisions.

Constructive feedback related to this manual is welcomed and will be thoughtfully considered by Part A grantee staff as updates and revisions are being made. All comments, suggestions or feedback should be forwarded to the Part A program supervisor, Anastassia Idov, at aidov@ccbh.net.

Ryan White Program Overview

History

The Ryan White Program was established in 1990 to improve the quality and availability of care for limited-income, uninsured, and underinsured individuals and families affected by HIV/AIDS. The program is named after Ryan White, an Indiana teenager living with HIV in the 1980s, who helped educate the nation on HIV and spoke out against AIDS-related discrimination.

The AIDS epidemic began in the early 1980s and has had the greatest impact on populations at high risk for poverty and with limited or no access to the health care system. Persons living with HIV/AIDS (PLWHA) are more likely to live at or below the federal poverty level when compared to the general population. Clients accessing Ryan White Program services are also more likely to have limited or no source of public or private payment necessary to receive HIV/AIDS-related services.

Ryan White Care Act Legislation

In August 2009, the U.S. Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to improve the quality and availability of health care services for low-income, uninsured, and underinsured PLWHA. The legislation has been reauthorized four times since its enactment, with the most recent reauthorization occurring in 2009. The Ryan White Treatment Extension Act expired on September 30, 2013, but funding has been extended in subsequent years through appropriations bills. This critical federal funding allows over 500,000 PLWHA to receive necessary health care each year.

Ryan White Program Extensions Act

1. **Language:**

   Under Title XXVI of the Public Health Services (PHS) Act, the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides flexibility to federal HIV/AIDS programs in order to respond effectively to the changing epidemic. In 2009, the Act extended the manner in which Ryan White funds can be used, with a continued emphasis on providing life-saving and life-extending services for persons living with HIV/AIDS across the country.

2. **Key Points of the 2009 Reauthorization:**

   - Minority AIDS Initiative (MAI) funds under Parts A and B of the Ryan White Program will be distributed according to a formula based on the distribution of populations disproportionately impacted by HIV/AIDS.

   - Continued issuance of Part A funds to Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) will be permitted on a case-by-case basis. For TGAs that lose their eligibility status, the state in which the TGA is located will receive incremental transfers of funding for three years.

   - A new requirement was implemented to determine not only the size and demographics of the diagnosed HIV/AIDS population, but also those who are infected but unaware of their HIV status. One-third of Part A supplemental grant funds are to be based on the EMA's/TGA's ability

to demonstrate its success in identifying infected individuals unaware of their status and linking them to care.

- Part A and Part B Recipients must develop comprehensive plans that include a strategy for identifying infected individuals who are not aware of their status and linking them to appropriate health care services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.

- The allowance for unobligated balances to be carried over into the next grant year increased from 2% to 5% of formula funds.

Guiding Principles of the 2009 Reauthorization of the Ryan White Program

The Ryan White Part A Program addresses the health needs of PLWHA by funding primary health care services and supportive services that enhance access to and retention in care. The following principles were crafted by the HIV/AIDS Bureau (HAB) to guide all funded Ryan White programs in implementing CARE Act provisions and addressing emerging challenges in HIV/AIDS care:

1. **Revise Care Systems to Meet Emerging Needs:**

   The Ryan White Program stresses the role of local planning and decision making with broad community involvement to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems to meet the needs of emerging communities and populations. A primary focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PLWHA who know their HIV status but are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services.

2. **Ensure Access to Quality HIV/AIDS Care:**

   The quality of HIV/AIDS medical care, including combination antiretroviral therapies and prophylaxis for opportunistic infections, can make a critical difference in the lives of PLWHA. Programs should implement quality management strategies to ensure that available treatments are accessible and delivered according to established and current HIV-related treatment guidelines.

3. **Coordinate Services with Other Health Care Delivery Systems:**

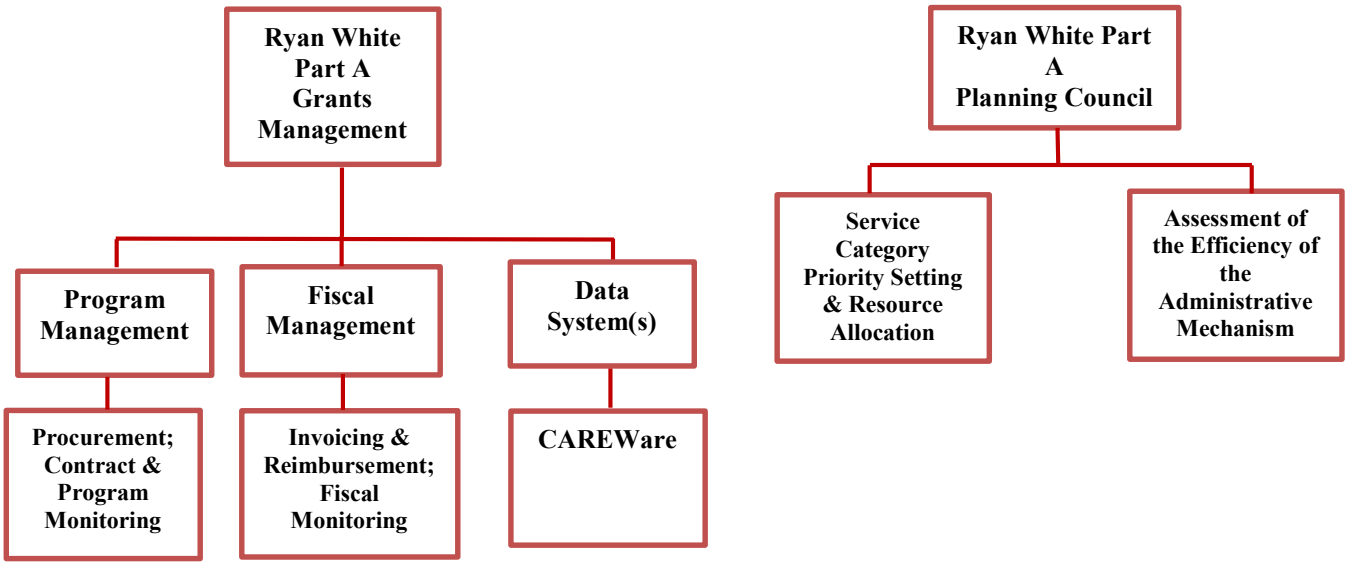
   Ryan White-funded services are meant to fill gaps in care, which requires coordination across Ryan White Parts A – F and other federal, state and local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS-related services within managed care plans, particularly Medicaid Managed Care.

4. **Evaluate the Impact of Funds and Make Needed Improvements:**

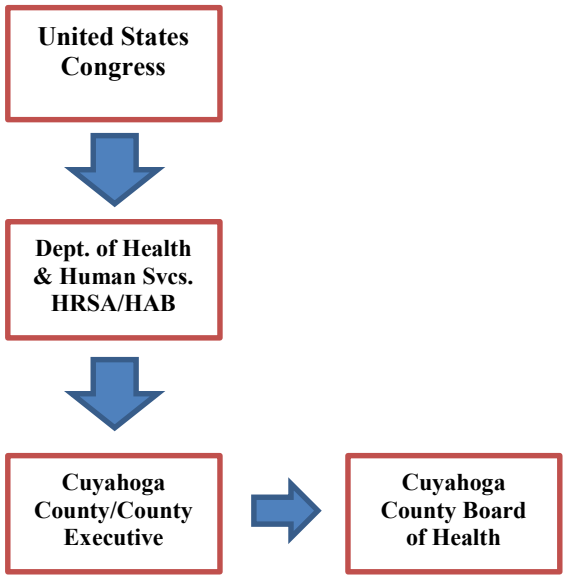
   Federal policy and funding decisions are increasingly determined by outcomes. Programs need to demonstrate the impact of Ryan White funds on improving access to quality care and treatment along with areas of continued need. Programs also need to have quality assurance and evaluation mechanisms in place that assess the effects of Ryan White resources on the health outcomes of PLWHA served.

Part A Structure

1. Program Management Structure



Funding Structure



The Greater Cleveland Transitional Grant Area (TGA) Ryan White Part A Grant Program is funded directly by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). The Ryan White Part A Program works in collaboration with the Cuyahoga Regional HIV Prevention and Care Planning Council to guide the prioritization and resource allocation of Part A-funded services. Services are provided through a network of contracted providers to support a full continuum of care.

Cuyahoga Regional HIV Prevention and Care Planning Council

The Cuyahoga Regional HIV Prevention and Care Planning Council represents the Transitional Grant Area (TGA) that includes the following counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, and Medina.

The mission of the Planning Council is to plan for the comprehensive delivery of HIV/AIDS services and allocation of resources for the TGA. The goal of the Planning Council is to identify HIV-positive individuals, ensure that they are linked into care, stay in care, and improve health outcomes.

The Planning Council consists of a maximum of thirty-five (35) members, at least 33% of which are persons living with HIV/AIDS. Members are appointed by the Cuyahoga County Executive. Council members identify and rank service priorities and determine funding allocations based on needs assessment data gathered from each local jurisdiction in the TGA and other relevant data.

Planning Council meetings take place online on the third Wednesday of each month from 5:30-7:00 p.m. Please see the meeting notices posted on www.ccbh.net for connection information. All meetings are open to the public.

The Cleveland TGA Planning Council also has five subcommittee groups:

1. Executive Committee: Members shall work with the Recipient agency to review monthly fiscal reporting data, review contract status data, establish the granting timelines, and monitor compliance with funding requirements.

2. Membership, Retention, and Marketing (MRM): Members will provide oversight and maintenance of the Planning Council membership outreach efforts to promote increased awareness and utilization of prioritized services for people living with HIV and AIDS.

3. Strategy & Finance (S&F): Members shall be responsible for oversight of the allocations and expenditures of direct services, as well as monitoring resource allocation and reallocation according to priorities set by the Planning Council and spending trends. This committee will also ensure the development of an ongoing process to evaluate and identify unmet service needs, which are eligible for funding through the Part A Program.

4. Community Liaison Committee (CLC): Members include community members who seek to improve Ryan White services by informing the Planning Council of their ideas, experiences and vision to improve the coordination of Ryan White services within the TGA and increase the health outcomes of PLWHA.

5. Quality Improvement (QI): This committee oversees all quality activities of the Ryan White Part A Program. The QI Committee ensures that services funded by Part A meet or exceed established HIV clinical standards and Public Health Services guidelines.

6. Prevention: Members provide insight about the effectiveness of the HIV prevention initiatives that are being administered in the region.

Priority Setting and Resource Allocation (PSRA) Information

The Planning Council determines the resources allocation mid-program year. Led by the Strategy & Finance (S&F) Committee, the PSRA process includes multiple activities that occur over several months.

i. Development and approval of a detailed PSRA work plan and timeline

ii. Formal written request to the Part A Recipient for a wide range of data.

iii. A series of trainings and presentations helping with interpreting complex epidemiological, service utilization, and community needs data to inform priority setting and resource allocations.

iv. Data Review to identify service categories to be highlighted in the PSRA Process. This is a series of conversations, either during the S&F Committee or in a Resource Allocation Workgroup, that develops criteria and analyzes data to identify several service categories that is highlighted during the discussion of the Full Planning Council. The criteria typically include:
    a. Items identified by the Community Liaison Committee
    b. Significant increase or decrease in the number of unduplicated clients (20% or more)
    c. Significant change in the priority ranking of a service category (5 or more steps)
    d. Significant increase or decrease in funds expended in a service category (25% or more)
    e. Significant over- or under-requesting of funds in the prior grant year.
    f. Significant increase or decrease in funds reallocated in the prior "reallocation" process.

v. Developing directives to improve the TGA's System of Care. This process is led by the Quality Improvement Committee.

vi. Prioritization all Part A service categories, including funded and non-funded services.

vii. Determine the final Part A funding allocations for the upcoming grant year

Determining Priorities: The Strategy & Finance Committee leads the priority setting by reviewing data for each criterion in the PSRA model for every service. The criteria typically used in the Cleveland TGA PSRA addresses the following questions:

a. **Payer of Last Resort** (weight factor 15%) – Is RW the ***only*** payer source available to consumers in the TGA for the service?
b. **Access/Maintenance in Care** (weight factor 35%) - Does the category promote access or maintenance in primary medical care?
c. **Specific Gaps/Emerging Need** (weight factor 25%) - Does the service address a specific service gap or service need? Does it address a newly identified or projected future need?
d. **Consumer Priority** (weight factor 25%) – Has the service category been specifically identified as a priority by PLWH?

Each criterion within the service category is assigned a score, multiplied by the weight factor, then added to tally the recommended rank.

Eligibility Policy

Policy Number: 100.01

Reviewed: April 8, 2025

Effective: November 17, 2021

Previous Version: April 1, 2017

I. Introduction

This policy outlines the roles, responsibilities, and requirements for establishing and maintaining Ryan White Part A Program client eligibility in the Cleveland TGA.

The program has established standard eligibility forms and uniform documentation requirements to increase the consistency of applicant eligibility-related experiences across agencies, while reducing duplicative applicant and staff efforts.

Throughout, emphasis is placed on the importance of ensuring that Ryan White is the "payer of last resort," as required under federal law, through documentation of ongoing agency efforts to identify and vigorously pursue client utilization of other third party payers, maximizing the impact of limited program resources.

II. Eligibility Criteria

Applicants must provide documents establishing the following:

1. HIV/AIDS diagnosis;

2. Cleveland TGA residency – Currently living in one of these Ohio counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain or Medina;

3. Low-Income – A MAGI-based monthly household income at or below 500% of the current Federal Poverty Level

4. Uninsured or Underinsured – Agencies must explore and eliminate all other possible sources of third party payment before using Ryan White funds to pay for a service(s). Clients with insurance or access to insurance must submit documentation of coverage.

III. General Policy Requirements

Agencies must establish and implement written policies and procedures which comply with this policy, the National Monitoring Standards; HRSA/HAB regulations, HAB policy notices and letters; contract terms; and all other applicable federal, state, and local statutes and requirements.

IV. Client Insurance Eligibility and Enrollment

Agencies are expected to make every reasonable effort to ensure uninsured clients are screened for eligibility in all possible public and private insurance options.

Agencies must have written policies and protocols in place to ensure they are vigorously pursuing client enrollment in health care options. They must inform uninsured clients of the consequences of not enrolling in a public or private health insurance option. They must have a written protocol outlining their required process for the pursuit of enrollment in health care coverage, including how the process will be uniformly documented and easily accessible to monitors. Agencies must ensure that eligibility protocols are uniformly and consistently implemented.

If after extensive documented agency efforts, a client remains un-enrolled in healthcare coverage, the client may be served by the program. Ryan White remains the payer of last resort, and agencies are expected to maximize all resources and health dollars in order to serve the most clients.

V. Personnel Requirements

Agency staff conducting eligibility must ensure that clients are aware of and access all other public and private third party payers for which they are eligible before accessing Ryan White funds. In order to ensure accurate Ryan White eligibility determinations, staff conducting eligibility assessments, must:

5. Have strong administrative, interviewing, and communication skills;

6. Communicate effectively, respectfully, and sensitively with clients from diverse cultural and demographic backgrounds and have the ability to assess client linguistic needs;

7. Be knowledgeable about Ryan White Part A eligibility requirements, policies and procedures;

8. Have knowledge and expertise regarding the Affordable Care Act and the key components being implemented in Ohio; be knowledgeable about Ohio's Medicaid expansion for low-income adults; and understand the eligibility and enrollment processes and requirements of both programs, as well as other public and private third party payment sources.

VI. Electronic Eligibility

All eligibility applications, forms, and verification documents must be uploaded to CAREWare. Each document must be clearly marked with the date it was obtained or completed. All eligibility information must be uploaded and named according to naming procedures.

VII. Agency Responsibility

To reduce the burden on applicants, eligibility documents should be uploaded into CAREWare in a timely fashion. Contractually, the responsibility for documenting the provision of allowable services to eligible clients rests with the agency providing services. Every agency providing services must ensure a client's eligibility is unexpired and documented in CAREWare at the time service is provided.

VIII. Recertification and Documentation Schedule

In order to establish and maintain continuous eligibility, an applicant must comply with the following recertification and documentation schedule:

	Initial Eligibility	Annual Eligibility
HIV Status	**Documentation required**	*No documentation*
Residency	**Documentation required**	**Documentation required**
Income	**Documentation required**	**Documentation required**
Insurance Status	**Documentation Required** (coverage, coverage denial, or of agency's ongoing vigorous efforts to enroll client required)	**Documentation Required** (coverage, coverage denial, or of agency's ongoing vigorous efforts to enroll client required)

IX. Initial Eligibility Determination

A new or returning applicant seeking program eligibility meets face-to-face with a member of the agency's eligibility staff to complete an Eligibility Application.

Eligibility is established when all verification and documentation criteria are met. See Section VIII for an overview of initial eligibility documentation requirements. These requirements are outlined in greater detail in the Eligibility Application and supporting documents. The applicant's self-report of initial eligibility criteria is not sufficient documentation.

Ryan White is the payer of last resort. Agency eligibility staff must screen the client for eligibility for other potential third-party payers and assist the client in completing related applications, as needed. Documentation of these efforts and copies of the third-party applications must be maintained in the client file.

X. Annual Recertification

In order to maintain eligibility, a client must complete annual recertification at least once every twelve months. During annual recertification, a client meets face-to-face with agency eligibility staff to complete an Eligibility Application.

See Section VIII for an overview of Annual Recertification documentation requirements. These requirements are outlined in greater detail in the Eligibility Application and supporting documents.

Ryan White is the payer of last resort. At annual recertification, agency eligibility staff must screen the client for eligibility for other potential third-party payers and assist the client in completing related applications, as needed. Documentation of these efforts and copies of the third-party applications must be maintained in the client file.

Standards of Care

Service standards of care (SOC) outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) service provider must follow when implementing a specific service category. The purpose of service SOC are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area. Service SOC establish the minimal level of service or care that a RWHAP funded agency or provider may offer within a state, territory or jurisdiction. They set a benchmark by which services are monitored and sub-recipient contracts are developed. Each funded service category must have a unique set of service standards. There may be some overlap of service SOC among two or more service categories (e.g., medical case management and non-medical case management may both assist with enrolling clients in insurance assistance programs).

Please reference the individual Standards of Care on our website at https://ccbh.net/ryan-white-provider-resources/ for detailed information pertaining to each funded service category.

Program and Fiscal Monitoring

Purpose of the Site Visit

The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the Ryan White Recipient conduct annual site visits with each Sub-Recipient to ensure compliance on proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place.

Sub-recipient Responsibility

1. Providers are required to maintain an individual case record or medical record for each client served.
2. All billed services match services documented in client records.
3. All records are kept in a secure place and in an organized fashion and available at the start of the monitoring visit.
4. Providers review and are familiar with service monitoring tools.
5. Assembling and preparing all necessary records and materials for completion of the service monitoring tools by the Recipient.
6. Have knowledgeable staff available to answer questions that may arise.
7. Make available to the Recipient all materials listed in Attachment A and Attachment B.
8. Submit fiscal policies to the Recipient within one month of receipt of electronic notification of site visit.
9. Provide timely follow-up when identified from the Recipient.

Recipient Responsibility Prior to the Site Visit

1. Providers will be notified electronically no later than ten days prior to an on-site visit of the date(s) and time(s) of visit.
2. The electronic notification will include Attachment A – Fiscal Monitoring Site Visit Checklist and Attachment B – Program Monitoring and Site Visit Checklist.

3. The Recipient will review the previous year's fiscal, program and quality monitoring report and corrective action if applicable.
4. No later than two (2) days before the monitoring site visit, the Recipient shall provide Attachment C, Monitoring Site Visit Random Sample Form, or the final list of records to be reviewed.

Recipient Responsibility During the Site Visit

1. **Conduct Opening Conference -** Upon arrival at the monitoring location, Recipient staff will meet with appropriate provider staff to discuss the purpose of the visit, review prior year monitoring outcomes, and address any questions the provider staff may have. The provider staff will be asked to explain how their charts or electronic medical records are organized so that data is accurately collected.
2. **Perform Monitoring -** Recipient staff will review the requested charts and documents as outlined in the notification, using the monitoring tools. A random sample of client records is chosen for review as a means of verifying that services are being provided in accordance with established standards and recorded accurately. In order to ensure efficiency and accuracy of the monitoring process, appropriate provider staff must be available to Recipient staff when needed throughout the monitoring process.

Recipient Responsibility Following the Site Visit

1. **Send a formal written report of the site visit findings -** A formal written report summarizing the monitoring site visit, including findings and recommendations, will be sent to each provider within 30 days of the site visit.
2. **Provide Technical Assistance -** Recipient staff will offer to provide technical assistance training on areas where deficiencies were noted.
3. **Conduct additional site visits as necessary -** Recipient office reserves the right to conduct additional site visits as necessary to verify the implementation of any recommended quality improvement activities. Agencies receiving results of 69% or below are subject to re-monitoring, as deemed necessary by Recipient Office on qualifying standards of the site visit report. Recipient staff will conduct a focused audit during any Follow-Up Site Visit within (6) six months following the adoption of a recommended Quality Improvement Plan.

Monitoring Performance Scale

Quality Score	Quality Rating	Follow-up Action
90 – 100%	**Excellent –** Findings exceed quality expectations	No action required.
80 – 89%	**Effective –** Findings meet quality expectations	No action required
70 – 79%	**Moderate Deficiencies –** Findings are below quality expectations	Written Corrective Action Plan required within 30 days of receipt of report.
69% and below	**Significant Deficiencies**	Probationary period put in effect; Written Quality Improvement Plan required within 30 days; Subject to re-monitoring until provider has addressed the finding and becomes compliant.

Significant Deficiencies Found During Site Visit

- When a programmatic site visit leads to the discovery of serious concerns about the quality of services that might negatively impact the health and safety of clients, Recipient staff will meet with the provider. The Recipient staff will provide a detailed overview of the concerns. This meeting will determine the appropriate manner in which the findings should be addressed and the appropriate sanction, if any, which should be imposed until the findings have been corrected.
- A Monitoring Performance Scale is used to determine when Quality Improvement Plans and Corrective Action Plans are necessary. Both plans address areas of deficiency, discuss changes that will be made to address deficiencies, and include a timeframe for implementation. Recipient staff will evaluate the provider's written response and notify the provider in writing of any findings to which the provider's response is not adequate. Depending on the severity of the deficiency, more than one monitoring visit during the grant cycle may be required.
- Any provider scoring between 70% and 79% on a qualifying standard will be required to submit a written Corrective Action Plan (CAP) to address the deficient areas within 30 days from the date of receipt of the monitoring report. The CAP must be implemented by the provider within 30 days of submission. The CAP will then be monitored during targeted trainings and technical assistance, as well as routine site visits.
- Any provider receiving a score of 69% or below are subject to re-monitoring as determined by the recipient. A written Quality Improvement Plan (QIP) will be required within 30 days of receipt of the monitoring report. The provider will have 30 days to implement the QIP from date of submission. Further action may be required if sub-recipient continues to have challenges.

Sample Corrective Action Plan:

A Corrective Action Plan sample is listed below, the full version of the document in Word format is available on the CCBH website at: **www.ccbh.net/ryan-white-provider-resources**

This form should be seen as only a sample; Sub-Recipients may choose to alter the form in any way to meet their own agency needs.

Finding: (Please include detailed description of audit finding)		
Corrective Action Plan: (Please detail the corrective action that will take place to fix the finding, including objectives, goals, and activities)		
Anticipated Completion Date:		
Person/Department Responsible:		
Position:	**Phone:**	**Email:**

FY2025 Ryan White Part A
Monitoring Site Visit Check List

Fiscal Monitoring

Please respond to each question separately and any documentation provided to support a response should be referenced with the respective question number.

1. How does your agency ensure reimbursement requests to CCBH don't include unallowable costs, direct or indirect, and that they conform to federal cost principles/Uniform Guidance? Provide policies and procedures to support your response.
2. Provide policy and/or process that guide the selection of an auditor.
3. Provide all financial policies and procedures including: billing and collection, purchasing and procurement, and accounts payable systems.
4. Does your agency receive program income? Provide policies and procedures regarding the handling of Ryan White revenues, including program income.
5. Provide allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources.
6. Provide property standards policy.
7. Provide a description of how Ryan White program staff is made aware of all required fiscal policies.
8. Provide a description of how fiscal staff is made aware of applicable federal regulations.
9. Does your agency establish a Medical Practice Management System for billing? If so, what is the name of the system? How it enables tracking of Ryan White program income separately from other income. Please explain. If the Medical Practice Management System can't perform this tracking, provide a description of how Ryan White program income is tracked.
10. Provide a description of how fiscal files are maintained and secured.

Please note, that unlike quality chart monitoring, fiscal monitoring is done for the current grant year in which you are delivering services. Please make sure that all policies and documents are your most current on file.

FY2025 Ryan White Part A
Monitoring Site Visit Check List

Program Monitoring

Please have the following program information available on the first day of the site visit:

1. Agency's Grievance Policy and Procedure.
2. Copy of eligibility policies, including agency policies that do not permit denial of service due to pre-existing or present health conditions and that do not consider VA health benefits as primary health coverage for the purposes of Ryan White.
3. Agency personnel policy handbook and/or manual.
4. Agency code of ethics and conflict of interest policies.
5. Documentation of any employee or board member violations of Code of Ethics policy.
6. Documentation of agency Corporate Compliance Plan in providing Medicare or Medicaid reimbursable services.
7. Copies of staff resumes, certifications, and licensures where required (please see Program Services Tool for details on requirements per service category).
8. Documentation that all staff involved in eligibility determination are properly trained.
9. Informational materials about agency services, newsletters, and promotional materials.
10. Consumer Advisory Board membership list, meeting notices, and meeting minutes.
11. Client satisfaction survey tools, analysis and documented use of results.
12. File of all Ryan White clients who were refused services, with the reason for refusal specified.
13. File of all formal client complaints received, grievances filed, and follow-up outcomes.
14. Progress report(s) on previously established corrective action plans or PDSA initiatives.
15. Documentation of established linkage agreements with key points of entry into the Ryan White system of care.
16. Documentation that a referral tracking system is in place for key points of entry into the Ryan White system of care.

Service category specific program requirements are outlined in the Program Services Tool. In addition to the items listed above, please make sure to review and prepare all service category requirements and have them available for review at the start of your scheduled visit.

http://www.ccbh.net/ryan-white-provider-resources

CAREWare

CAREWare is a free, HRSA-sponsored software used to manage and monitor HIV clinical and supportive care, as well as produce federally required service reports. CAREWare is updated regularly to be compliant with HAB reporting requirements. The software is scalable and can be customized to meet local needs.

The Cleveland TGA began using the CAREWare data collection system in 2011. The Cleveland TGA CAREWare database is hosted on our own secure server and meets all federal, state and local privacy standards. All Cleveland TGA subrecipients are required to enter data using the CAREWare system. Due to changes in HRSA/HAB reporting requirements and availability of new features or modules, the Cleveland TGA CAREWare software is typically updated every 6-8 months. Only clients that meet our TGA's eligibility requirements should be entered into the Cleveland TGA's CAREWare system.

Please reference the Ryan White Part A Program Cleveland TGA CAREWare 6.0 Manual at https://ccbh.net/ryan-white-provider-resources/ for more information on how CAREWare is utilized for data reporting and collection.

General Program Requirements

Program Reports

The Sub-Recipient responsibilities include the following:

1. Semi-annual Program Reports will be submitted to the Board twice per program year. Templates will be provided to the Sub-Recipient in the beginning of the program year. Responses are to be thoughtful and reflective of the services provided. Failure to properly report at the 6-month deadline may be marked as "non-compliant".

2. Annual Administrative Reports and Ryan White HIV/AIDS Program Services Report (RSR) required by HHS/HRSA/HAB. The format for the Annual Administrative Reports will be provided to the Sub-Recipient by the Board with instructions on completion. All RSR data will be collected through CAREWare.

3. Monthly Fiscal Reports in the form of monthly invoices detailing the allowable billable services performed during the previous calendar month.

4. Timely responses to Ryan White Part A RFPs during competitive grant cycles.

5. Other additional reporting may be requested by CCBH

Failure by the Subrecipient to produce timely and adequate reports will impact the Subrecipient's funding during the current contract period, as well as its eligibility for consideration for funding in subsequent years.

Certification of Client Eligibility

It is the responsibility of the Subrecipient to determine and document client eligibility status in CAREWare and as outlined in the Ryan White Part A- Cleveland TGA Eligibility Policy as well as RWHAP Policy 13-02. Agencies may not provide Ryan White services under presumptive eligibility; eligibility must be confirmed prior to enrollment/recertification. If a client is eligible for other third party reimbursement, it is the responsibility of the Subrecipient to bill the appropriate third party for services.

Access to Records

The Subrecipient shall retain, maintain and keep accessible all records relevant to this Agreement for a minimum of six (6) years, following Agreement termination, or full performance, or any

longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Subrecipient shall maintain all financial records in accordance with generally accepted accounting principles. All other records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, the Subrecipient shall permit authorized representatives from the Board and HHS access to the records at reasonable times and places for purposes of inspection, audit, examination and copying.

Grievance Procedure

The Subrecipient shall provide the Board with written notification of any concerns or complaints. Where a conflict cannot be resolved, the Subrecipient may initiate a grievance process which shall consist of mediation and, if necessary, binding arbitration.

Notices

All notices, invoices and correspondence which may be necessary or proper for either party shall be addressed as follows:

TO THE BOARD:
Cuyahoga County Board of Health
Attention: Anastassia Idov
Supervisor, Ryan White Part A
5550 Venture Drive
Parma Ohio 44130
(216) 201-2001

TO THE SUBRECIPIENT:
Name/Title
Address
City, State, Zip
Phone Number

Staff Changes

Changes of Subrecipient staff supported in whole or in part by funds awarded through this Agreement, require prior written approval of the Board. If prior written approval is not obtained, related expenses may not be reimbursed.

Salary Limitation

The Subrecipient shall not use funds awarded under this contract to pay the salary of an individual at a rate in excess the Executive Level II salary of the Federal Executive Pay scale, as required under the Consolidated Appropriations Act, 2012 (P.L. 112-74), December 23, 2011, which limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements.

Sub-Recipient Responsibilities and Guidelines for Ryan White Part A Services

The Sub-Recipient shall perform the following activities:

Program Standards

The Sub-Recipient responsibilities include the following:

1. Deliver professional services in a manner consistent with the corresponding public health standards, generally accepted best practices and professional protocols, and the definition for service as established by the U.S. Department of Health and Human Services, Health Resources Services Administration HIV/AIDS Bureau.

2. Adhere to the Standards of Care derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures, as well as the Cleveland TGA Standards of Care. The Standards of Care will be provided to the Sub-Recipients at the beginning of the grant year and made available on the Board's webpage. Any changes or updates to the Standards of Care within the grant year will be provided to the Sub-Recipient via a Policy Change Notification through email and will be posted on the Board's website.

3. Make services available to any eligible individual without regard to ability to pay or health condition of the individual. Services will be provided to clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

4. Provide each client with information and referral regarding all RW Act Part A services and providers and other community services for persons living with HIV/AIDS.

5. Promote consumer-driven access to primary care and other services as appropriate.

6. Advertise, promote and market RW Act Part A services to your existing client base and the community for new clients collectively through the Board following HRSA guidelines for targeted advertising.

7. Participate in an HIV community-based continuum of care, to the extent such a continuum exists.

8. Attend mandatory meetings with other RW Act Part A agencies for the purpose of training, networking, exchanging information, sharing resources, and formalizing linkages.

9. Participate in the comprehensive planning process for the organization and delivery of HIV- related health and support services developed by the Cuyahoga Regional HIV

Prevention and Care Planning Council.

10. Document a plan to have active consumer advisory participation attached to the Sub-Recipient's service delivery program. Sub-Recipient can utilize an independent consumer group to meet these criteria or engage the Consumer Liaison Committee of the Cuyahoga Regional HIV Prevention and Care Planning Council to meet this requirement.

11. Participate in ongoing stakeholders' meetings and/or task forces aimed to increase, enhance, and maintain coordination and collaboration among HIV-related health and support service providers.

12. Participate and complete activities necessary to develop and support a Ryan White Part A Clinical Quality Management Program to assess the quality of care and health outcomes of local Ryan White Part A-funded services.

13. Contact the Board at any time during the contract service year to discuss any program or fiscal questions or concerns that impact service delivery or billing.

14. All providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or receive a waiver from this requirement.

15. The Sub-Recipient is required to maintain an individual record for each client served. The record shall contain:

    a. Documentation of eligibility and required forms as outlined in Ryan White Part A-Cleveland TGA Eligibility Policy. The Sub-Recipient must maintain all client eligibility records in CAREWare in a manner designated by the Board.
    b. A signed copy of a client release of information form.
    c. A signed client rights/responsibilities statement.
    d. Original and revised case notes specific to service standards and protocols.
    e. Treatment or service plans specific to service standards and protocols.
    f. Any required medical or other referral or certification required to receive specific services.
    g. Appropriate documentation or verification of appointment(s), attendance or receipts for services.
    h. Other documentation required by the Sub-Recipient or accrediting or certifying entity.
    i. Notations of all client contact/treatment as required by service standards and documentation for invoicing.
    j. Additional information may be required specific to Service Standards or the Ryan White Part A Program.

16. If a client requests to be served by another provider, the Sub-Recipient is required to:
    a. Honor the request for transfer
    b. Provide the client with a list of other community providers to choose from, and

c. transfer a copy of all necessary client records to the new provider upon receipt of a request by the client or provider.

CAREWare Data

The Sub-Recipient responsibilities include the following:

1. Comply with CAREWare data entry requirements for client-level data, services input, EHB reporting and eligible scope requirements identified by the Board.

2. It is expected that Sub-Recipients collect accurate and comprehensive client-level service data of all Ryan White Part A clients. The data is to be entered in its entirety prior to the invoice submission for the service month.

3. Review staff time and efforts to ensure appropriate percentages are being charged back to the grant. Ensure staff productivity levels are represented in CAREWare.

4. Upload into CAREWare all eligibility documents within three business days of obtaining completed documents from a client.

5. Submit all required CAREWare forms as deemed necessary by the Board, including user agreements and confidentiality forms for all employees utilizing the CAREWare system, acknowledging compliance with policies and procedures as provided by the Board.

Fiscal Reports and Invoices

The Sub-Recipient responsibilities include the following:

1. Sub-Recipient will use the Sub-Recipient Certified Expenditure Report as well as other specified documents and provide the Board with copies of receipts or contracts as validation of expenditures when submitting requests for payment. Supporting documentation is required for all reimbursements.

2. The services billed must match the services documented in the client record. The specific invoicing format will be provided by the Board.

3. Sub-Recipient shall maintain original documentation, such as time sheets, payroll journals, tax records, travel vouchers, vendor invoices, lease agreements, canceled checks, logs and receipts in a manner that will expedite an on-site fiscal monitoring of program costs.

4. Sub-Recipient must submit budget justification narrative that describes how categorical costs are determined, specific functions of the personnel, and justify equipment, travel, supplies and training costs. A budget justification is required for establishing budgets and budget revisions.

5. Sub-Recipient must report any staffing changes that impact the approved budget on file within seven business days

6. Review staff time and efforts to ensure appropriate percentages are being charged back to the grant.

7. Sub-Recipient administrative costs may not exceed 10% of total direct costs for any service category at any time during the grant year.

8. All invoices must be submitted to the Board on, or before the specified due date.

9. All budget revisions and budget requests must be submitted on, or before the date requested.

10. Fiscal reports and invoices may not be approved or delayed by the Board if they are not submitted correctly. This includes invoices, narratives, receipts, and budget templates. Expenses must be approved in the budget narrative, and correspond with a line item within that approved budget.
    a. Sub-recipients who use gift cards, gas cards, and other incentives must log each provision.
    b. Program participants who receive gift cards from Sub-Recipients must sign off upon receiving it.
    c. Receipts are needed for all expenses to be reimbursed.

Unallowable Costs

The Sub-Recipient responsibilities include the following:

1. Ryan White HIV/AIDS program funds cannot be used to pay for Pre-Exposure Prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP)

2. Funds awarded for pharmaceuticals must only be spent to assist clients who have been determined not eligible for other pharmaceutical programs, especially the AIDS Drug Assistance Program and/or for drugs that are not on the State ADAP or Medicaid formulary.

3. 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 HIV/AIDS BUREAU POLICY 16-02 4 cash intended as payment for HRSA RWHAP core medical and support services. Where direct provision of the service is not possible or effective, store gift cards,2 vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

4. Payments for any item or service to the extent that payment has been made, or can be reasonably expected to be made with respect to that item or service under any State compensation program, insurance policy, Federal or State health program or by an entity

that provides health services on a prepaid basis (except Indian Health Services or US Department of Veteran Affairs).

5. Ryan White Part A grant funds may not be used for outreach programs which have HIV prevention education as their exclusive purpose or broad scope awareness activities about HIV services that target the general public.

6. Incentive costs or payments (by check, gift card, or other mechanism) to volunteers or patients participating in a grant-supported project or program or to motivate individuals to take advantage of grant-supported health care or other services unless Sub-Recipient receives prior written consent of the Board.

7. Employment and Employment-Readiness Services, except in limited, specified instances (e.g., Non-Medical Case Management Services or Rehabilitation Services)

8. Funeral and Burial Expenses
9. Property Taxes
10. Clothing
11. Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity
12. International travel
13. The purchase or improvement of land
14. The purchase, construction, or permanent improvement of any building or other facility

Clinical Quality Management (CQM)

Ryan White Part A recipients are required to implement Clinical Quality Management activities. Specifically, the Ryan White Program legislation dictates that all recipients must: "establish a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent PHS guidelines for the treatment of HIV disease and related opportunistic infections. As applicable, recipients should develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." In addition to legislative requirements, HRSA/HAB requires recipients to establish and implement a written Clinical Quality Management Plan to guide quality related activities in the local service area.

The overall mission of the Cleveland Transitional Grant Area Clinical Quality Management Program is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV care and services provided to all HIV-infected individuals served by the TGA. Culturally and linguistically competent medical and social service provider's work collaboratively with administrative staff and consumers to create, implement, and maintain a dynamic program to facilitate receipt of comprehensive, state of the art, high quality care. This Clinical Quality Management Program aligns with the 2022-2025 National HIV/AIDS Strategy goals, and adheres to established HIV clinical practice standards and Public Health Service guidelines in order to best address the needs of the Cleveland TGA community.

The vision of the TGA Clinical Quality Management Program is to improve and enhance the health and wellness of the population we serve. Through the work of the Clinical Quality Management Committee, the CQM Program aims to become a local resource for anyone wishing to improve the outcomes and support services of HIV health care for consumers, communities, and public health.

The Clinical Quality Management Program works towards meeting or exceeding HAB expectations to establish and maintain a clinical quality management program and alignment with the National HIV/AIDS Strategy 2020 (NHAS). The Clinical Quality Management Program includes documented accountability for all service provision, with quantitative performance measurement and capacity building for providers and consumers resulting in ongoing and meaningful improvement activities.

Please reference the Ryan White Part A Program Cleveland TGA 2024 Clinical Quality Management Plan on our website at www.ccbh.net/ryan-white-provider-resources for more information such as CQM infrastructure, capacity building, performance measurement, QI projects and monitoring, stakeholder involvement, evaluation, and communication within the committee.

Additional Resources

CAREWare User Manual – Click Here

CQM Work Plan 2024 – Click Here

Eligibility Application – Click Here

Appendix

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Early Intervention Services (EIS):

Counseling individuals with respect to HIV/AIDS; testing (not funded through Ryan White Part A); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

RWHAP Part A EIS services must include the following four components:

1) Targeted HIV testing (not funded through Ryan White Part A) to help the unaware learn their HIV status and receive referrals to HIV care and treatment services if found to be HIV infected. Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
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

Services should be targeted to the following populations:

- Newly diagnosed
- Receiving other HIV/AIDS services but not in primary care
- Formerly in care – dropped out
- Never in care
- Unaware of HIV status

EIS programs must have signed linkage agreements to work with key points of entry.
Given that EIS leads EIIHA (Early Identification of Individuals with HIV/AIDS) efforts, EIS programs must coordinate with prevention services, counseling and testing centers, as well as other RW Part A providers.

Rev. March 2024
In effect as of 2025

Early Intervention Services (EIS)

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

An individual providing Early Intervention Services (EIS) must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

All EIS staff working outside of a primary medical care facility must be certified by the Ohio Department of Health as an HIV Prevention Counselor and Tester as evident through certification on file, or, if partnering with an outside testing agency, have the partnering agency's staff certification on file.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of EIS is to bring identified high risk clients into, or back into, medical care through intensive short-term case management services.

Clinical Quality Improvement outcome goals for EIS are:

- 80% of all EIS client files include documentation of referral to health care and supportive services.
- 70% of EIS clients are linked to care as documented by at least one medical visit, viral load or CD4 test within 90 days of first visit/service.

Early Intervention Services (EIS)

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Early Intervention Services are provided by qualified professionals.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable targeted subpopulations as documented through staff personnel records.	100%
2.	Agencies providing EIS include testing, referral, linkage and education program components into their project work plans.	Documentation of the provision of all four required service components with Part A funding or other funding partnerships available for review.	100%
3.	Agencies providing EIS have established memoranda of understanding (MOUs) with key points of entry into care and linkage agreements with partnering testing agencies.	Documentation of all executed MOUs and linkage agreements available for review.	100%
4.	Agencies providing EIS coordinate project activities with HIV prevention efforts and programs.	Documentation that agency's work in partnership with prevention services as to not duplicate any service activities.	100%
5.	All EIS HIV testing activities meet CDC and State testing requirements.	If providing EIS services outside of a primary medical care facility, documentation of ODH HIV Prevention Counselor and Tester certification or equivalent for staff from formal partnering agency is made available for review.	100%
6.	Agencies providing EIS document and report all administered HIV tests and positive screenings.	Documentation of monthly tracking of administered HIV tests and positives made available for review.	100%
7.	Agencies providing EIS track all referrals to and from the program.	Documentation of the number of referrals from key points of entry to the EIS program and to health care and supportive services from EIS made available for review.	100%
8.	EIS client can be associated with one or more of the five target populations: 1) newly diagnosed; 2) receiving HIV/AIDS services but not in HIV medical care; 3) formerly in HIV medical care but dropped out; 4) never in HIV medical care; 5) unaware of HIV status	Documentation of need for EIS services is evident in the client file.	80%
9.	EIS clients receive health education and literacy training that enables them to better navigate the HIV system of care. Some examples include HIV education, HIV services available within the TGA, disease progression, treatment options, system navigation tips, etc.	Documentation of health education and literacy training is included in the file of all clients receiving services in the measurement year.	80%
10.	EIS clients are referred to health care and supportive services.	Documentation of referrals to health care and supportive services are included in the file of all clients receiving services in the measurement year.	80%

Rev. March 2024
In effect as of 2025

Early Intervention Services (EIS)

11.	* Clients are transitioned out of EIS once EIS objectives are met and/or client is proven to be in stable medical care.	* Documentation is included as an EIS notation that the client has been referred and/or transferred out of EIS services once noted as stably in medical care.	80%

*** Indicates Local TGA Standard of Care**

All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Early Intervention Services (EIS)

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Emergency Financial Assistance:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential medications or prescription eye wear. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted. Agencies providing medication assistance under Emergency Financial Assistance must be a current Cleveland Ryan White Part A provider of Outpatient Ambulatory Health Services with the required 340B certification.

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White HIV/AIDS Program funds for these purposes will be the payer of last resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should not be funded through EFA.

* Requests for exceptions must be submitted to the Grantee through the Cuyahoga County Board of Health Ryan White Part A Program Service Exception Request Form.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Emergency Financial Assistance

PERSONNEL QUALIFICATIONS

Emergency Financial Assistance (EFA) service providers dispensing medications shall adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Ohio.

EFA providers providing medication assistance must also be enrolled in the Federal 340B Drug Pricing Program.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of the Emergency Financial Assistance (EFA) program is to provide formulary approved HIV/AIDS medications or prescription eye wear on a temporary basis to eligible individuals living with HIV/AIDS in the TGA to ensure access to therapies for improved and/or sustained health.

Clinical Quality Improvement outcome goals for EFA include:

- 80% of all files include an assessment of presenting need and qualification for EFA service.
- 80% of EFA clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year

Emergency Financial Assistance

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Service providers dispensing medications adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Ohio.	Documentation of current pharmacy license for the State of Ohio is reviewed.	100%
2.	Service provider is enrolled in the Federal 340B Drug Pricing Program.	Documentation of current 340B certification is reviewed.	100%
3.	Client file includes an assessment of presenting problem / need requiring EFA services.	Documentation of eligibility and need evident in the client chart.	80%
4.	Client file includes a description of the date and type of EFA provided.	Documentation of date and description of EFA drug(s) distributed evident in the client chart.	80%
5.	Drugs distributed under EFA are included on the approved Ohio Drug Assistance Program formulary or the agency has received prior approval through the exception request process with the Grantee.	Documentation that distributed drug(s) is/are on the approved formulary or have received prior-approval evident in the client chart.	80%
6.	* Client file includes documentation that a third party application was completed and is pending approval.	* Documentation of a third party payer application evident in the client chart.	80%
7.	Client did not receive EFA services for longer than 90 days.	Documentation that EFA services were limited to 90 days or less evident in the client chart.	80%
8.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client report).	80%
9.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Emergency Financial Assistance

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Food Bank/Home Delivered Meals

SERVICE CATEGORY DEFINITION

Food Bank/Home Delivered Meals:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes 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

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

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Food Bank/Home Delivered Meals

PERSONNEL QUALIFICATIONS

Any agency providing services in the Food Bank/Home Delivered Meals (FB/HDM) category must comply with federal, state, and local regulations regarding the provision of food bank services, food item delivery and/or home delivered meals including any required licensure and/or certifications to operate the particular food service program involved.

All personnel being billed for delivering meals and/or any food items must hold a valid Ohio driver's license and automobile insurance consistent with state minimum requirements. This also applies to delivery personnel whose agencies may have customized their FB/HDM programs as detailed in their proposal to the Grantee.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Food Bank/Home Delivered Meal services is to assist eligible people living with HIV/AIDS in the TGA with food assistance to ensure access to adequate caloric intake and balances nutritional meals to optimize health outcomes.

Clinical Quality Improvement outcome goals for Food Bank/Home Delivered Meals are:

- 100% of all agencies providing services maintain proper licensure as required by the state of Ohio, pertaining to program service delivery approved by the Grantee.
- 80% of food bank/home delivered meal clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Food Bank/Home Delivered Meals

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Food Bank/Home Delivered Meal services are provided by agencies that maintain appropriate required licensure.	Documentation of appropriate food licensure or licensure required for food delivery personnel reviewed. ***For clarification, please see Personnel Qualifications section above**	100%
2.	Agencies providing Food Bank/Home Delivered Meals collect and maintain signed receipts for all resources distributed.	Documentation of a signed receipt for all services received is maintained and available for review in the client chart.	100%
3.	* Clients receiving home delivered meals have documented medical necessity of need updated at least every six months (~180 days) or sooner if noted by physician.	* A written physicians referral documenting the home delivery as a medical necessity including the diagnosis and length of time the physician expects the patient will require home delivered meals is evident in the client chart.	80%
4.	Food Bank/Home Delivered Meal clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart.	80%
5.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Food Bank/Home Delivered Meals

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Home and Community-Based Health Services

SERVICE CATEGORY DEFINITION

Home and Community-Based Health Services:

Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider.

Services 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.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Home and Community-Based Health Services

PERSONNEL QUALIFICATIONS

Staff providing Home and Community-Based Health Services may include, but are not limited to: home health aides, nurses, physical therapists, and/or social workers. Depending on the scope of practice, staff must meet the appropriate licensure and/or certification requirements set forth by the State of Ohio where applicable.

Each agency providing Home and Community-Based Health Services must have and implement a plan for supervision of all staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Home and Community-Based Health services within the Cleveland TGA is to provide high quality in-home services that assist with increasing activities of daily living (ADL) and adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for Home and Community-Based Health Services include:

- 80% of Home and Community-Based Health Services clients have a written care plan signed by a clinical health care professional.
- 80% of Home and Community-Based Health Services clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Home and Community-Based Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Home Health Care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	Home Health Care agencies are appropriately licensed by the state of Ohio and able to bill Medicare, Medicaid, private insurance, and/or other third party payers.	Documentation of agency licensure/s reviewed.	100%
3.	Client file includes written care plan signed by a clinical health care professional indicating the need for services.	Documentation of care plan evident in client chart.	80%
4.	Client file includes written care plan that specifies type of services needed and the quantity and duration of care.	Documentation of care plan evident in client chart.	80%
5.	* Client written care plan is reviewed and/or updated at least every 90 days.	* Documentation of treatment plan update evident in client chart.	80%
6.	Client file includes documentation of type of home service provided, the date of service, and the signature of the professional who provided each service.	Documentation of service details and professional signature evident in client chart.	80%
7.	* Client file includes documentation of ongoing communication with the client's health care team (i.e. referring physician; medical case manager).	* Documentation of communication with client's health care team evident in client chart.	80%
8.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client report).	80%
9.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Home and Community-Based Health Services

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Home Health Care

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Home Health Care:

The provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services 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 diagnostic testing administered in the home
- Other medical therapies

Services require a medical referral stating the need for home health services and the expected length of care. 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.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Home Health Care

PERSONNEL QUALIFICATIONS

Home Health Care services will be provided by trained licensed or certified health care workers such as nurses. Depending on the scope of practice, staff must meet the appropriate licensure and/or certification requirements set forth by the State of Ohio.

Each agency providing Home Health Care must have and implement a plan for supervision of all staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Home Health Care services within the Cleveland TGA is to provide high quality in-home services that assist with increasing activities of daily living (ADL) and adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for Home Health Care services include:

- 80% of Home Health Care clients have a written care plan in place.
- 80% of Home Health Care clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Home Health Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Home Health Care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	Home Health Care agencies are appropriately licensed by the state of Ohio and able to bill Medicare, Medicaid, private insurance, and/or other third party payers.	Documentation of agency licensure/s reviewed.	100%
3.	Client file includes documentation of type of home service provided, the date of service, and the signature of the professional who provided each service.	Documentation of services provided and provider signatures evident in client chart.	80%
4.	Client file includes documentation that services are limited to medical therapies in the home and exclude personal care services.	Documentation of services provided evident in client chart.	80%
5.	* Client file includes documentation of the physician referral for home health care services and expected length of time that services will be needed.	* Documentation of physician's referral evident in client chart.	80%
6.	* Client file includes documentation that the treatment plan is reviewed and/or updated at least every 90 days.	* Documentation of treatment plan update evident in client chart.	80%
7.	* If client is discharged, client file includes reason for termination of services.	* Documentation of reason for discharge evident in client chart.	80%
8.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Home Health Care

		measurement year evident in the client chart (can be client report).	
9.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

Home Health Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Medical Case Management

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Case Management:

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 may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). Key activities include:

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

In addition to providing the medically oriented services above, Medical Case Management may also provide benefit 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 Marketplace/Exchanges).

Individuals providing medical case management must be a licensed social worker and are expected to have specialized training in medical case management models.

Medical Case Management includes all provisions listed above and requires a patient whose acuity level requires the case manager also manage their medical care, schedule and monitor medical appointments, lab work, medication treatment adherence, other indicated services including dietician, mental health and substance abuse screenings/treatment and other supports.

Rev. March 2024
In effect as of 2025

Medical Case Management

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

An individual providing medical case management services must be a licensed social worker and follow the National Association of Social Work (NASW) Standards for Case Management, available for review at: www.socialworkers.org/practice/naswstandards

Each medical case management agency must have and implement a written plan for supervision of all medical case management staff consistent with licensure status. Medical case managers must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical case management is to provide care planning and coordination services needed for people living with HIV/AIDS, ensuring access to core and support services that will enable medical adherence and stability for each individual client.

As part of this service category, all medical case managers are required to administer a standardized psychosocial assessment and complete an accompanying acuity scale every six months, for every client on their caseload.

Clinical Quality Improvement outcome goals for medical case management are:

- 80% of all client files include documentation of a completed comprehensive care plan.
- 80% of clients receiving medical case management services are actively engaged in medical care as documented by a medical visit in each six (6) month period in a two-year measure and in the second half of a single year measure.
- 80% of clients receiving medical case management services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 80% of clients receiving medical case management services are virally suppressed as documented by a viral load of less than 200 copies/mL at last test.
- 80% of clients receiving medical case management services have their individual care plans updated at least 2 times per year; every effort will be made to update at least 3 months apart.

Medical Case Management

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	Medical case management clients have a completed comprehensive individual care plan.	Documentation of completed comprehensive individual care plan is included in the file of all clients receiving services in the	80%
3.	Newly enrolled medical case management clients receive an initial assessment of service needs within the first month of services.	Documentation of initial assessment of service needs is included in the file of all clients entering service in the measurement year.	80%
4.	Medical case management clients receive coordinated referrals and information for services required to implement the care plan.	Documentation of referrals and service coordination are noted in the file for clients receiving services in the measurement year.	80%
5.	Medical case management clients have their individual care plans updated at least 2 times per year; every effort will be made to update at least 3 months apart.	Documentation that the individual care plan is updated at least two times, three months apart, for clients receiving services for a span longer than six months in the measurement year.	80%
6.	Medical case management clients are continuously monitored to assess the efficacy of their individual care plan.	Documentation of continuous monitoring to assess the efficacy of the care plan is evident in the client chart.	80%
7.	Medical case management clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented by the medical case manager.	80%
8.	Medical case management clients are retained in medical care.	Documentation that the client had at least one medical visit in each six month period of a 24 month measurement period with a minimum of 60 days between visits as documented by the medical case manager.	80%
9.	Medical case management clients have no gaps in medical care.	Documentation that the client had a medical visit in the first and second halves of a 12 month measurement period as documented by the medical case manager.	80%
10.	Medical case management clients are on Antiretroviral Therapy (ART).	Documentation that client was prescribed ART in the 12-month measurement year as documented by the medical case manager.	80%
11.	Medical case management clients are virally suppressed.	Documentation that the client has a viral load <200 copies/mL at last test as documented by the medical case manager.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Medical Case Management

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Ryan White Part A

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Nutrition Therapy:

Medical Nutrition Therapy includes:

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

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

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Medical Nutrition Therapy

PERSONNEL QUALIFICATIONS

Depending on the scope of practice, an individual providing medical nutrition therapy must be licensed and qualified within the laws of the State of Ohio by one of the following licensing boards:

- Ohio Board of Dietetics
- American Dietetic Association

Each agency providing medical nutrition therapy must have and implement a plan for supervision of all medical nutrition staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical nutrition therapy within the Cleveland TGA is to provide high quality treatment and counseling services to address the nutritional needs of individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for medical nutrition therapy include:

- 80% of all medical nutrition therapy clients have a nutrition plan in place.
- 80% of medical nutrition therapy clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Medical nutrition therapy services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	* Staff providing services have been trained to work within the population.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	80%
3.	Client file includes date service was initiated and the planned number and frequency of sessions.	Documentation of initiation date and frequency plan evident in client chart.	80%
4.	Client file includes a nutrition plan with recommended services and course of medical nutrition therapy provided with signature of assigned medical nutrition therapist.	Documentation of nutrition plan and professional signatures evident in client chart.	80%
5.	* Nutrition Plan is updated as necessary and signed by RD annually.	Documentation of nutrition plan updates evident in client chart.	80%
6.	Where food prescription is indicated, client file includes recommendation for services by healthcare provider with prescribing privileges.	Documentation of provider's recommendation evident in file.	80%
7.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client reported).	80%
8.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Medical Nutrition Therapy

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Medical Transportation

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Medical Transportation:

Medical Transportation is the provision of nonemergency transportation services 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 for 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)
- Organization and use of volunteer drivers (though programs with insurance and other liability issues specifically addressed)
- A voucher or token system

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Medical Transportation

PERSONNEL QUALIFICATIONS

Staff administering medical transportation services must possess a comprehensive knowledge of local transportation assistance options and internal medical transportation policies. This policy must be on file at the Cuyahoga County Board of Health.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of medical transportation is to provide transportation services needed for people living with HIV/AIDS to ensure access to core and support services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for medical transportation are:

- 80% of medical transportation files include the reason for each trip and its relation to accessing health and support services.
- 80% of medical transportation clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Medical Transportation

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Medical transportation client file includes a description of the type of services, i.e. bus tickets, Uber, etc., and number of trips provided	Documentation of service evident in client chart.	80%
2.	Medical transportation client file includes the reason for each trip and its relation to accessing health and support services.	Documentation of allowable activities evident in client chart.	80%
3.	If providing gas cards or taxi assistance, the medical transportation client file includes the trip origin and destination.	Documentation of trip origin and destination evident in client chart.	80%
4.	If providing gas cards, the mileage reimbursement does not exceed the current federal reimbursement rate.	Documentation of federal reimbursement rate calculations evident in client chart.	80%
5.	Medical Transportation client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client self-report).	80%
6.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Medical Transportation

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Mental Health Services

SERVICE CATEGORY DEFINITION

Mental Health Services:

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

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Mental Health Services

PERSONNEL QUALIFICATIONS

Depending on the scope of practice, an individual providing mental health services must be licensed and qualified within the laws of the State of Ohio by one of the following licensing boards:

- Ohio Counselor, Social Worker and Marriage and Family Therapist Board
- Ohio Board of Psychology
- Ohio Board of Nursing
- State Medical Board of Ohio

Each agency providing mental health services must have and implement a plan for supervision of all mental health staff consistent with licensure status and scope of practice. Staff must be evaluated at least annually by their supervisor according to written agency policy on performance appraisals.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of mental health services within the Cleveland TGA is to provide high quality treatment and counseling services to address mental illness, eliminating barriers to treatment and increasing adherence to medical care for eligible individuals living with HIV/AIDS.

Clinical Quality Improvement outcome goals for mental health services include:

- 80% of all mental health clients have a diagnosis of mental illness or a mental health condition.
- 80% of all mental health client files include documentation of a completed comprehensive care plan.
- 80% of mental health services clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year.

Mental Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Mental health services are provided by trained professionals.	Documentation of current Ohio licensure/s reviewed.	100%
2.	Clients receiving mental health services have a detailed treatment plan that includes the diagnosis of mental health illness or condition.	Documentation of diagnosis of mental health illness or condition evident in the client chart.	80%
3.	Clients receiving mental health services have a detailed treatment plan that includes the treatment modality (group or individual).	Documentation of treatment modality recommendation evident in the client chart.	80%
4.	Clients receiving mental health services have a detailed treatment plan that includes the start date for mental health services.	Documentation of start date for mental health services evident in the client chart.	80%
5.	Clients receiving mental health services have a detailed treatment plan that includes the recommended number of sessions.	Documentation of recommended number of sessions evident in the client chart.	80%
6.	Clients receiving mental health services have a detailed treatment plan that includes the date for reassessment; reassessment occurs at least 1x per measurement year.	Documentation of recommended date for reassessment evident in the client chart.	80%
7.	Clients receiving mental health services have a detailed treatment plan that includes the projected treatment end date.	Documentation of projected treatment end date evident in the client chart.	80%
8.	Clients receiving mental health services have a detailed treatment plan that includes any recommendations for follow up.	Documentation of recommendations for follow up evident in the client chart.	80%
9.	Clients receiving mental health services have a detailed treatment plan that includes the signature for the mental health professional rendering service.	Documentation of signature for mental health professional rendering the service evident in the client chart.	80%
10.	Mental health clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year	80%
11.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Mental Health Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Non-Medical Case Management Services:

Non-Medical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management services have as their objective improving health care outcomes.

Services may focus on:

- Housing coordination and referral assistance to enable an individual to gain or maintain access to and compliance with HIV related medical care and treatment. Or,
- Benefit coordination to include assisting eligible clients to obtain access to other public and private programs for which they may be eligible.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individual care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptions as necessary
- Ongoing assessment of the client's and other key family member's needs and personal support systems

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Non-Medical Case Management Services

PERSONNEL QUALIFICATIONS

An individual providing non-medical case management services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of non-medical case management services is to provide housing and benefit coordination for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for case management non-medical are:

- 100% of Non-Medical Case Management Services are provided by case managers trained to work with the population that they serve.
- 80% of Non-Medical Case Management clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Non-medical case management services are provided by qualified professionals.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2.	Client file includes documentation of the date of each encounter.	Documentation of date of encounter evident in client chart.	80%
3.	Client file includes documentation of the duration of each encounter.	Documentation of duration of encounter evident in client chart.	80%
4.	Client file includes documentation of type of each encounter (e.g. face-to-face, phone, etc.).	Documentation of type of encounter evident in client chart.	80%
5.	Client file includes documentation of key activities performed during each encounter.	Documentation of key activities of each encounter evident in client chart.	80%
6.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client report).	80%
7.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%
Non-Medical Case Management – Benefit Coordination Only			
8.	Services are focused on assisting client in obtaining access to both public and private benefit programs for which they may be eligible.	Documentation that services tie to benefit coordination evident in client chart.	80%
Non-Medical Case Medication – Housing Specialist Only			
9.	* Client file includes a completed individual care plan specific to housing.	* Documentation of completed housing plan evident in client chart.	80%
10.	* Client file includes documentation that services are focused on housing information and referrals to enable an individual to gain or maintain access to and compliance with HIV-related medical care and treatment.	* Documentation of activities evident in client chart.	80%
11.	* Client file includes documentation of completed housing inspection in situations where client relocates.	* Documentation of activities evident in client chart, including housing inspection verified by housing case manager.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Non-Medical Case Management Services

Cleveland TGA Service Standard of Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Oral Health Care

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Oral Health Care:

Oral Health Care services provide outpatient diagnostic, preventative, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Oral Health Care

PERSONNEL QUALIFICATIONS

An individual providing Oral Health Services must be a dental health care professional licensed and certified to provide health care in the State of Ohio. Professionals may include:

- General Dental Practitioner
- Dental Specialists
- Dental Hygienists
- Trained Dental Assistants

All services provided must be in compliance with state dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Oral Health Services is to provide diagnostic, preventative and therapeutic dental care to all eligible individuals living within the TGA.

Clinical Quality Improvement outcome goals for oral health services include:

- 100% of all oral health client files have a dental treatment plan developed or updated in the measurement year.
- 80% of all oral health client files include documentation of oral health education provided at least once in the measurement year.
- 80% of oral health clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Oral Health Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	Oral health clients have a dental treatment plan developed or updated in the measurement year.	Documentation of completed dental treatment plan is included in the file of all clients receiving services in the measurement year.	100%
3.	Oral health clients have a dental and medical health history recorded or updated in the measurement year.	Documentation of completed dental and medical health history is included in the file of all clients receiving services in the measurement year.	80%
4.	Oral health clients receive oral health education at least once in the measurement year.	Documentation of oral health education is included in the file of all clients receiving services in the measurement year.	80%
5.	Oral health clients receive a periodontal screening or exam at least once in the measurement year.	Documentation of periodontal screening is included in the file of all clients receiving services in the measurement year.	80%
6.	Oral health clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart.	80%
7.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

* All standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Oral Health Care

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Other Professional Services (Legal)

SERVICE CATEGORY DEFINITION

Other Professional Services (Legal):

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 individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
  - Assistance with public benefits such as Social Security Disability Insurance
  - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RWHAP
  - Preparation of:
    - Healthcare power of attorney
    - Durable powers of attorney
    - Living wills
- Permanency Planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation of custody options for legal dependents including standby guardianship, joint custody, or adoption

Unallowable services include criminal defense and/or class-action suits unless related to access to services eligible for funding the Ryan White HIV/AIDS Program.

Rev. March 2024
In effect as of 2025

Other Professional Services (Legal)

Cleveland TGA Service Standard of Care

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

PERSONNEL QUALIFICATIONS

All legal counsel services must be performed by trained professional staff. Attorneys must have current licensure to practice before a court with jurisdiction in the Cleveland TGA.

Paralegal staff or other non-licensed staff must be supervised by an attorney.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of legal services is to address legal matters directly necessitated by an individual's HIV status so that the client can ensure adherence and maintenance to primary medical care treatment.

Clinical Quality Improvement outcome goals for legal services are:

- 100% of all client files include a completed legal assessment.
- 80% of legal service clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Other Professional Services (Legal)

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Legal services are provided by licensed professionals.	* Documentation of current licensure to practice before a court with jurisdiction in the Cleveland TGA made available to review.	100%
2.	* Paralegal staff or other non-licensed staff must be supervised by an attorney.	* Documentation that paralegal and other non-licensed staff are supervised by an attorney with supervisory records kept on file and made available for review.	100%
3.	Client file includes a description of how the legal service is necessitated by the individual's HIV status.	Documentation of how the legal service is necessitated by HIV status in included in the file of all clients receiving services in the measurement year.	80%
4.	* Client files include a completed legal assessment.	* Documentation of completed legal assessment is included in the file of all clients receiving services in the measurement year.	100%
5.	Client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client record (can be client report).	80%
6.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Other Professional Services (Legal)

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE CATEGORY DEFINITION

Outpatient/Ambulatory Health Services:

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Non-HIV related visits to urgent care facilities are not allowable costs. Emergency room visits are not allowable costs.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Outpatient/Ambulatory Health Services

PERSONNEL QUALIFICATIONS

Outpatient/Ambulatory Health Services must be provided by trained licensed or certified health care workers.

Individual clinicians shall have documented unconditional licensure/certification in his/her particular area of practice as required by Federal, state and local regulations with credentials appropriate for treating HIV-infected clients.

Clinicians are required to:

- Provide direct, ongoing care to at least 20 HIV patients within the 24 months preceding the date of review.
- Complete a minimum of 20 credits of HIV-related CME/CEU/CE or documentation of HIV-related lectures/educational activities within the 24 months preceding the review.

Clinical staff must also have documented unconditional licensure/certification in his/her particular are of practice as required by Federal, state and local regulations and be experienced in the area of HIV/AIDS clinical practice as evident in their personnel files. All clinical staff without direct experience with HIV/AIDS services shall be supervised by one who has such experience. That supervision must be evident in personnel files and made available for review.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of Outpatient/Ambulatory Health Services is to provide effective diagnostic and therapeutic medical care services that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for Outpatient/Ambulatory Health Services:

- 80% of clients receiving Outpatient Ambulatory Health Services are actively engaged in medical care as documented by a medical visit in each six (6) month period of a 24-month measurement period with a minimum of 60 days between visits.
- 80% of clients receiving Outpatient Ambulatory Health Services are prescribed Antiretroviral Therapy (ART) in the measurement year.
- 80% of clients receiving Outpatient Ambulatory Health Services are virally suppressed as documented by a viral load of less than 200 copies / mL at last test.

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
1.	Primary medical care services are provided by trained professionals.	Documentation of current Ohio licensures reviewed.	100%
2.	Laboratory services are provided at professional facilities.	Documentation that includes certifications, licenses, or FDA approval of the laboratory from which tests are ordered is reviewed.	100%
3.	* Clinicians complete a minimum of 20 HIV-related education credits within the 24 months preceding the date of review.	* Documentation of CME/CEU/CE, lectures, or educational activities received in the 24 months preceding the date of review.	100%
4.	* Clinicians provide direct, ongoing care to at least 20 HIV positive clients within the 24 months preceding the date of review.	* Documentation of case load summaries reviewed.	100%
5.	Agencies conduct regular quality improvement activities that focus on HIV care and process measures.	Documentation of quality improvement activities reviewed.	100%
6.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident in client chart.	80%
7.	Client had viral load test performed at least every six months.	Documentation of viral load test outcomes evident in client chart.	80%
8.	Client was prescribed HIV Antiretroviral therapy during the measurement year.	Documentation of HIV Antiretroviral therapy evident in client chart.	80%
9.	Client had one medical visit in each 6-month period of a 24-month measurement period with a minimum of 60 days between visits.	Documentation of medical visit history evident in client chart.	80%
10.	Clients 6 years of age and older are prescribed PCP prophylaxis within 3 months of CD4 count below < 200 cells/mm.	Documentation of PCP prophylaxis prescription evident in client chart.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
11.	Clients aged 1-5 are prescribed PCP prophylaxis within 3 months of CD4 count < 200 cells/mm.	Documentation of PCP prophylaxis prescription evident in client chart.	80%
12.	Clients ages 6 weeks-12 months were prescribed PCP prophylaxis at the time of HIV diagnosis.	Documentation of PCP prophylaxis prescription evident in client chart.	80%
13.	Client had HIV resistance test ordered prior to the initiation of ART if ART is initiated during the measurement year.	Documentation of resistance test evident in client chart.	80%
14.	Client had a fasting lipid panel completed if client was on ART during the measurement year.	Documentation of fasting lipid panel evident in client chart.	80%
15.	Client had a TB screening test and results interpreted at least once since HIV diagnosis.	Documentation of TB screening test and results evident in client chart.	80%
16.	Client received influenza vaccine or reported receipt through other provider between October 1st and March 31st of the measurement year or documentation of client refusal.	Documentation of influenza vaccine evident in client chart.	70%
17.	Client ever received pneumococcal vaccine or documentation of client refusal.	Documentation of pneumococcal vaccine evident in client chart.	80%
18.	Client had Hep C screening at least once since HIV diagnosis.	Documentation of Hep C screening evident in client chart.	80%
19.	Client had Hep B screening at least once since HIV diagnosis.	Documentation of Hep B screening evident in client chart.	80%
20.	Client had Hep B vaccine series if not Hep B positive or documentation of client refusal.	Documentation of Hep B vaccine series evident in client chart.	80%
21.	Adult client, assigned female at birth, had cervical PAP screening, reported receiving screening, or was referred to OB/GYN within the last 3 years.	Documentation of PAP screening, self-report, or OB/GYN referral.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Outpatient/Ambulatory Health Services

Cleveland TGA Service Standard of Care

SERVICE STANDARDS

	Standard	Measure	Goal
22.	Client had annual screening for syphilis.	Documentation of annual syphilis screening evident in client chart.	80%
23.	Client had annual screening for chlamydia if they were new to services, were sexually active, or had an STI in the last 12 months.	Documentation of annual screening for chlamydia evident in client chart.	80%
24.	Client had annual screening for gonorrhea if they were new to services, were sexually active, or had an STI in the last 12 months.	Documentation of annual screening for gonorrhea evident in client chart.	80%
25.	Client received an oral exam by a dentist at least once during the measurement year based on client self-report.	Client received an oral exam from a dentist, reported receiving an oral exam, or was referred to a dentist at least once during the measurement year.	80%
26.	Client received HIV risk counseling during the measurement year.	Documentation of HIV risk counseling evident in client chart.	80%
27.	Client received screening for clinical depression during the measurement year.	Documentation of clinical depression screening evident in client chart.	80%
27 a.	If clinical depression screen was positive, client received follow-up plan on the same date of encounter.	Documentation of follow-up plan evident in client chart.	80%
28.	Client received screening for tobacco use at least once in a 24-month period.	Documentation of screening for tobacco evident in client chart.	80%
28 a.	If tobacco screening was positive, client received tobacco cessation counseling intervention or referral.	Documentation of referral or tobacco cessation intervention evident in client chart.	80%
29.	New clients received screening for substance use (alcohol & drugs) during the measurement year.	Documentation of substance abuse screening evident in client chart.	80%
30.	Outpatient/Ambulatory Health Services clients have been educated on viral load suppression and Undetectable=Untransmittable.	Documentation that client had discussion with healthcare professional about viral load suppression and Undetectable=Untransmittable.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Outpatient/Ambulatory Health Services

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.

Psychosocial Support Services

SERVICE CATEGORY DEFINITION

Psychosocial Support Services:

Psychosocial Support Services provide group or individual support and counseling services to include HIV support groups to assist eligible people living with HIV to address behavioral and physical health concerns.

CLIENT INTAKE AND ELIGIBILITY

All agencies are required to have a client intake and eligibility policy on file. It is the responsibility of the agency to determine and document client eligibility status, as outlined in the Ryan White Part A—Cleveland TGA Eligibility Policy.

Eligible clients must:

- Live in the Cleveland TGA (Cuyahoga, Ashtabula, Lake, Lorain, Geauga, or Medina County)
- Have an HIV/AIDS diagnosis
- Have a household income that is at or below 500% of the federal poverty level
- Be uninsured or underinsured

Services will be provided to all Ryan White Part A-qualified clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Rev. March 2024
In effect as of 2025

Psychosocial Support Services

PERSONNEL QUALIFICATIONS

An individual providing psychosocial support services must have a basic knowledge of HIV/AIDS and/or infectious disease and be able to work with vulnerable targeted subpopulations as documented through personnel records.

CARE AND QUALITY IMPROVEMENT OUTCOME GOALS

The overall treatment goal of psychosocial support services is to provide group support and therapy for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Clinical Quality Improvement outcome goals for psychosocial support services are:

- 80% of psychosocial support clients have received education specifically geared towards the importance of medical adherence.
- 80% of psychosocial support clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test in the measurement year.

Psychosocial Support Services

SERVICE STANDARDS

	Standard	Measure	Goal
1.	* Psychosocial Support services are provided by qualified professionals.	* Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2.	* Documentation is maintained of all topics discussed through support group with correlating sign-in sheets.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
3.	* Access and engagement in primary care topics were discussed with the client at least once in a 3-month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
4.	* Access and engagement in medical case management was discussed with the client at least once in a six month period.	* Documentation of agendas/notes, and sign-in sheets reviewed.	80%
5.	Psychosocial client is linked to medical care.	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart (can be client report).	80%
6.	Client had less than 200 copies/mL at last HIV Viral Load test during the measurement year.	Documentation of viral load test outcomes evident through Cleveland TGA CAREWare Performance Measure.	80%

*** Indicates Local TGA Standard of Care**
All other standards derived from the HRSA/HAB National Monitoring Standards and/or the HRSA/HAB HIV Performance Measures

Rev. March 2024
In effect as of 2025

Psychosocial Support Services

CLIENTS RIGHTS AND RESPONSIBILITIES

Agencies providing services are required to have a statement of consumer rights and responsibilities posted and/or accessible to the client. Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.

CLIENT RECORDS, PRIVACY, AND CONFIDENTIALITY

Agencies providing services must comply with the Health Insurance Portability and Accountability Act (HIPAA) provisions and regulations and all federal and state laws concerning confidentiality of consumers Personal Health Information (PHI). Agencies must have a client release of information policy in place and review the release regulations with the client before services are received. A signed copy of the release of information form must be included in the client's record. Information on all clients receiving Ryan White Part A-funded services must be entered in the HRSA sponsored, Cleveland Part A managed, CAREWare Database.

CULTURAL AND LINGUISTIC COMPETENCY

Agencies must provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (Pulled from the National Standards on Culturally and Linguistically Appropriate Services).

CLIENT GRIEVANCE PROCESS

Each agency must have a written grievance procedure policy in place which provides for the objective review of client grievances and alleged violations of service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so. A signed copy of the grievance procedure policy form must be included in the client's record.

CLIENTS RIGHTS AND RESPONSIBILITIES

Each agency providing services should have a case closure protocol on file. The reason for case closure must be properly documents in each client's file. If a client chooses to receive services from another provider the agency must honor the request from the client.