City of Detroit Department of Health and Wellness Promotion

HIV Emergency Relief Grant Program,
Ryan White HIV/AIDS Treatment Extension Act of 2009
Part A

NEW PROVIDERS

Fiscal Year 2010
Competitive
Program Guidance

Application Meeting: January 13, 2010

Application Due Date: Friday, January 22, 2010, 4:00 p.m.

December 15, 2009

Dear Colleague:

I am pleased to report that the City of Detroit Department of Health and Wellness Promotion (DHWP) - HIV/AIDS Programs is beginning its nineteenth year of grant administration under the HIV Emergency Relief Grant Program, Ryan White HIV/AIDS Treatment Extension Act of 2009 - Part A. Funds will be available to fund services in the Detroit Eligible Metropolitan Area (EMA) which encompasses the city of Detroit and the counties of Wayne, Oakland, Macomb, Monroe, Lapeer, and St. Clair.

Ryan White funds provide direct financial assistance to areas that have been the most severely affected by the HIV epidemic and assist them in the development and/or enhancement of access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV disease. *A comprehensive continuum of care includes Outpatient/Ambulatory Medical Care (primary medical care) for the treatment of HIV infection that is consistent with Public Health Service guidelines.* Such care includes access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections as well as a combination of antiretroviral therapies. Comprehensive HIV/AIDS care also includes access to mental health, home and community based health services, medical case management, early intervention services, medical nutritional therapy, and HIV medications. In addition, this continuum of care includes supportive services that enable individuals to access and remain in primary medical care as well as other health or supportive services that promote health and enhance quality of life.

Funding for FY 2010 for new providers will be a competitive process to address service delivery from March 1, 2010 through February 28, 2011. The proposal can be downloaded at www.drugfreedetroit.org or can be picked up **after Monday, January 4, 2010** at the Detroit Department of Health and Wellness Promotion, 1151 Taylor, Room 455C between the hours of 8:00 am to 4:00 pm. All applications must be submitted by 4:00 pm, on Friday, January 22, 2010. For further information, contact Carletta Smiley, Ryan White Care Services Manager at (313) 876-4954 or SmileyC@detroitmi.gov.

There will be a technical assistance meeting on Wednesday, January 13, 2010 at DHWP in the 7th Floor Chapel from 10:00 am to 2:00 pm, for all prospective entities interested in submitting a competitive proposal. The agenda will include a discussion of the competitive proposal process.

Thank you for your interest in serving the HIV/AIDS community.

Sincerely,

Andrea Roberson, MHSA
Director, HIV/AIDS Programs

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SECTION I

A. PROGRAM AUTHORITY

This document is provided to assist agencies eligible and interested in applying for funds under Part A, of the "HIV Emergency Relief Grant Program" of the Ryan White HIV/AIDS Treatment Extension Act of 2009**,** to prepare their fiscal year (FY) 2010 grant application.

The Detroit Eligible Metropolitan Areas (EMA) includes the jurisdictions of the city of Detroit and the surrounding counties of Wayne, Oakland, Macomb, Monroe, Lapeer, and St. Clair.

Part A programs are administered by the Division of HIV Services (DHS), Bureau of Health Resources Development (BHRD), Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau's (HAB) Division of Service Systems (DSS), Department of Health and Human Services (DHHS). Part A funds, awarded through the Treatment Extension Act to the Detroit EMA, are administered through the City of Detroit Department of Health and Wellness Promotion (DHWP). Part A funds designated for the Detroit EMA (Region I) are administered by the DHWP.

B. PURPOSE OF FUNDS

The principal intent of Part A funding is to provide direct financial assistance to EMAs that have been the most severely affected by the HIV epidemic. The purpose is to assist EMAs in developing or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV. A comprehensive continuum of care includes primary medical care (including treatment of HIV infection consistent with Public Health Service guidelines, access to drug therapies including opportunistic infections prophylaxis/treatment and combination antiretroviral therapies), mental health, medical case management, early intervention, medical nutritional counseling, and home & community based health care; supportive services that enable individuals to access and remain in primary care; and other health or supportive services that promote health and enhance quality of life.

Through a priority setting process led by the Southeastern Michigan HIV/AIDS Council (SEMHAC), the EMA/region funds providers to deliver or enhance access to the services as listed below. Additionally, **all funded services must create linkages that will increase/enhance access to Outpatient/Ambulatory Medical Care (Primary Medical Care) services and improve patient adherence to medical treatments.**

Outpatient/Ambulatory Medical Care
Medical Transportation
Housing Assistance
Medical Nutrition Therapy
Psychosocial Support
Non- Medical Case Management
Legal Services
Outreach Services
Referral
Oral Health Services
Food Bank/Home Delivered Meals
Medical Case Management
Emergency Financial Assistance
Mental Health Services
Treatment Adherence
Early Intervention Services
Health Education/Risk Reduction
Home & Community Based Health Services
AIDS Drug Assistance Program (ADAP)

The HIV/AIDS Bureau (HAB) recognizes that Part A EMAs have in the past developed continuums of care that attempted to meet the needs of all Persons Living with HIV (PLWH) within the EMA. Centers of Disease Control's (CDC) Initiative "Advancing HIV Prevention: New Strategies for a Changing Epidemic" may identify significant new numbers of PLWH who will be seeking services. This will require a careful reassessment of how the Detroit EMA will assure access to primary care and medications, and ensure provision of critical support services necessary to maintain individuals in the system of care. In light of the CDC initiative and efforts underway to describe unmet need, EMAs were instructed to allocate funds to essential core services which are: 1) Outpatient/Ambulatory Medical Care; 2) Medical Case Management; 3) AIDS Drug Assistance Program; 4) Medical Nutrition Therapy; 5) Mental Health; 6) Early Intervention Services; 7) Oral Health Care; 7) Home & Community Based Health Services.

C. PROGRAM SCOPE AND FY 2010 PROGRAM FOCUS

HRSA has established long-range strategies to support their mission of improving the nation's health by assuring equitable access to comprehensive quality health care. Consistent with funding requirements, DHWP is placing particular emphasis on the following four strategies as a key component of the FY 2010 Part A funding process:

Strategy I: Reduce Barriers to Care
Strategy II: Reduce Health Disparities
Strategy III: Improve Quality of Care
Strategy IV: Strengthen Health Care Access

New Focus Areas (as of 12/15/09):
Strategy V: Early Identification of Individuals living with HIV/AIDS
Strategy VI: Minority AIDS Initiative (MAI)
NOTE: MAI funding will revert to a formula distribution award date of 3/1/10

In preparing the FY 2010 non-competing-continuation proposal, existing subcontractors should consider the four existing and <u>two new strategies</u> identified by HRSA as having significant implications for HIV/AIDS care services and treatment and refer to them as they develop their HIV/AIDS care implementation plans for FY 2010 and future years. In addition to HRSA's strategies, the Ryan White Treatment Extension Act of 2009 emphasizes the use of funds to address the service needs of "individuals who know their HIV status and are not receiving such services and for informing the individuals of and enabling the individuals to utilize the services, giving particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities".

In addition, Part A Planning Councils (PCs) are still required to determine the size and demographics of the estimated population who is aware of its HIV status. Effective September 30, 2009, under section 2604(b)(4) of the PHS Act, as amended by the Ryan White HIV/AIDS Extension Act of 2009, Public Law 111-87, PCs are now required to determine the size and demographics of the estimated population of individuals who are unaware of their HIV status. In addition, the PCs must develop a strategy for identifying those with HIV/AIDS who do not know their status, make them aware of their status, and refer them into care.

D. AWARD INFORMATION

Fiscal Year 2010 Ryan White Part A funds will be in the form of non-competing-continuation and competitive awards (to address gaps in services, targeted populations, new strategies and planning council directives) and are **subject to the availability of funds.**

Summary of Funding

The Detroit Eligible Metropolitan Area's (EMA) base or formula funding for Part A is determined by the number of living cases of HIV/AIDS.

Per the HRSA guidance received on 12/16/09, one-third (1/3) of the total score for the objective review of the supplemental portion of the fiscal year (FY) 2010 Grant Application will be calculated based on the following factors: 1) the number of individuals who were tested for *HIV/*AIDS; 2) of those who were tested, the number who were made aware of their status, including the number who tested HIV positive; and, 3) of those described in clause 2, the number who were referred to appropriate treatment and care.

Therefore, each funded provider will be required to closely track the number of clients new to the HIV continuum of care.

In fiscal year 2009, the Detroit EMA received $8,119,507 in Ryan White Part A funds. The amount of funds available for each service category was determined by the FY 2008 priority setting process.

PLEASE NOTE: The federal Ryan White Treatment Extension Act of 2009 Part A budget is not expected to increase for FY 2010. As funding decreases, it is imperative for Grantees to evaluate the costs of services in dispersing Treatment Extension Act funds.

E. FUNDING RESTRICTIONS

1) Grant funds may not be used to supplant or replace current State HIV-related funding

2) Funds may not be used to purchase vehicles, land or improve land or to purchase, construct or make permanent improvements to any building except for minor remodeling.

3) Ryan White funds are funds of last resort and may not be used to provide items or services for which payment has already been made or can reasonably be expected to be made, by third party payers, including Medicaid, Medicare, and/or other State or local entitlement programs, prepaid health plans or private insurance. Funds may not be used to make direct payment to recipients of services. A voucher system must be developed.

F. Ryan White Part A/ GRANTEE ASSURANCES

The funded provider agrees to:

1) Permit authorized representatives of the Department, Project Sponsor, Federal Grantor Agency, Comptroller General of the United States, or any of their duly authorized representatives, to review all electronic and/or paper records, files, and documentation related to this agreement.

2) Provide, consistent with regulations set forth by the federal Office of Management and Budget, a copy of the annual audit of the Agency to the Department within the period

specified by OMB Circulars A-128 AND A-133.

3) Participate in site visits/objective reviews conducted by the Department of Health and Wellness Promotion and/or HRSA.

4) Maintain appropriate liability insurance coverage.

5) Enter service data into electronic database as required by the Grantee and/or HRSA.

6) Comply with the Detroit Living Wage Ordinance as required.

7) Become a part of the comprehensive continuum of care plan for organization and delivery of HIV-related health and support services.

8) Participate in designated meetings, taskforce or workgroup sponsored by SEMHAC or the DHWP for the purpose of increasing, enhancing or maintaining coordination of services in the Detroit EMA.

9) Participate in SEMHAC's annual assessment of the administrative mechanism.

10) Participate in the bi-annual needs assessment process conducted by SEMHAC.

11) Inform individuals of the availability of services funded by the Treatment Act and enhance access for such individuals to these services.

12) Submit timely programmatic and fiscal reports to the DHWP. The schedule for these reports will be provided to you once an award has been determined.

13) Upon request, providers will be expected to participate in Grantee/HRSA/Planning Council evaluation studies.

14) Recipients of Part A funds must participate in a community-based continuum of care.

    Continuum of care is defined as: *A comprehensive range of services required by individuals or families with HIV infection in order to meet their health care and psychosocial service needs throughout the course of their illness. The concept of a continuum suggests that services must be organized to respond to the individual or family's changing needs in a holistic, coordinated, timely, and uninterrupted manner which reduces fragmentation of care.*

SECTION II
COMPETITIVE REQUEST FOR PROPOSAL

A. APPLICATION AND SUBMISSION INFORMATION

1. There will be a technical assistance meeting on January 13, 2010 at the Department of Health and Wellness Promotion in the 7th Floor Chapel from 10:00 am to 2:00 pm, for entities interested in submitting a competitive proposal. The agenda will include a discussion of the competitive application process. The agenda will include a review of the RFP.

2. **The entire proposal may not exceed 60 pages in length**, including the abstract, project and budget narratives, attachments, appendices and letters of commitment and support. Pages must be numbered consecutively.

Proposals that exceed the 60-page limit will be deemed non-compliant. All non-compliant applications will be returned to the applicant without further consideration.

Number of Copies
Please submit one (1) original proposal and three (3) copies. Proposal must be single sided. **DO NOT** staple or bind the proposal.

Font
Applications must be in easily readable serif typeface (Times New Roman or CG Times). Use a standard size black type that is no less than 11.5 characters per inch. Use a minimum 1.5 or double-spaced lines in the text. **Proposals not adhering to the point font or line spacing requirements may be returned unread.**

Paper Size and Margins
For scanning purposes, please submit the proposal on 8.5" by 11" white paper. Margins must be at least one (1) inch at the top, bottom, left and right of the paper. Please left align text.

Numbering
Please number the proposal sequentially from page 1 (Table of Contents) to the end of the application, including charts, figures, tables and appendices.

Section Headings: Please put all section headings flush left in **bold type.**

Table of Contents
Provide a Table of Contents for the remainder of the proposal (including appendices), with page numbers.

Submit all copies of proposal **UNBOUND.**

B. APPLICATION NARRATIVE

1. Program Abstract

Provide a one (1) page summary of the application that is clear, accurate, concise, and without reference to other parts of the proposal. It must include: 1) a brief description of the proposed grant program including the needs to be addressed, 2) the proposed services, 3) the population group(s) to be served and, 4) the funding request. Abstract may be single-spaced.

Describe in the abstract three major areas as follows:

a. General demographics of your target population;

b. Geography of the EMA with regard to communities affected by HIV/AIDS and the location of proposed HIV/AIDS services in relation to those communities;

c. Description of how the proposed services fit within the EMA's continuum of care. Those seeking funding for primary care should include relevant information about the primary medical care services and how they are delivered. Those seeking funding for other supportive services should describe how clients are referred to and supported in HIV primary medical care.

2. Program Narrative

This section is the bulk of your application. It provides a comprehensive description of all aspects of the service delivery system. It must be brief, self–explanatory and well organized so that reviewers can understand your proposed program and how it fits within the system of care within the EMA.

THE FOLLOWING ARE THE SECTION HEADERS FOR THE APPLICATION NARRATIVE

a. **Access to Care Services**

Describe the program's proposed role in the continuum of care for FY 2010 vs. FY 2009. Emphasize how the system of care addresses the service needs of newly infected/affected and underserved populations — including disproportionately impacted communities of color, emerging populations, those who know their HIV and AIDS status but are not presently in the system of HIV/AIDS primary medical care and (**NEW**) how the program proposes to make unaware individuals aware of their HIV positive status and refer them into appropriate care, and 2) how the program proposes to focus on Detroit EMA Minority AIDS Initiative (MAI) targeted populations of African Americans, Hispanics, and Youth.

Describe how the proposed program is consistent with HRSA's goals of increasing access to services, reducing barriers to care and decreasing disparities among affected subpopulations and historically underserved communities. This should include information on mechanisms within the program design that enable newly infected,

underserved and/or hard-to-reach individuals or communities to access and remain in primary medical care. Include the following in this description:

1) The critical population(s) to be served
2) Established links with target population(s) and agency's experience serving this population
3) Plan to make services known to underserved populations
4) Plan to engage and maintain clients in HIV primary care
5) Proposal to make unaware individuals aware of their HIV positive status and refer them into appropriate care

b. **Implementation Plan**

The purpose of this section is to describe the FY 2010 service delivery plan with specific attention to ensuring access to a continuum of HIV/AIDS care. The plans must demonstrate how the program will reduce or eliminate service and health outcome disparities. The plans must address the needs of those persons in the continuum of care as well as those who know their HIV status but are not in HIV/AIDS primary medical care.

Describe the proposed service delivery plan and how it will ensure access to HIV/AIDS primary medical care and support services and reduce disparities in access to care. Include the following in this description:

1) Organizational capability, capacity and infrastructure: The Grantee believes that the great majority of its subcontractors are competently managed, responsible, and fully committed to achieving the objectives of the grants they receive. Clearly describe how the organization will assure grant compliance and the stewardship of grant funds.

2) Staffing Plan and Personnel Requirements: Discuss organizational structure including all staff and volunteer involvement and required staff qualifications. Provide an organizational chart inclusive of <u>HIV services</u> and the proposed <u>program</u>. Include a list of the current board members inclusive of position/role, address, telephone number and e-mail address in your appendices.

3) Other participating organizations and their roles (as appropriate).

4) Addressing Unmet Need:
   Discuss increased access to the HIV continuum of care by describing:
   a) How your organization will address the needs of emerging populations;
   b) How your organization will encourage PLWH/A to remain in HIV/AIDS primary medical care and adhere to HIV treatments;
   c) How your organization will increase access to the HIV continuum of care for communities where HIV prevalence is increasing, minority communities disproportionately impacted by HIV disease and persons who know their HIV status but are not in HIV/AIDS primary medical care.

5) The interventions that will be implemented to meet client needs and to achieve required outcomes and minimum thresholds as noted in Appendix B. Programs may measure

other aspects of care service delivery as needed or desired.

6) Proposal to make unaware individuals aware of their HIV positive status and refer them into appropriate care.

7) The mechanism to closely track the number of clients new to the HIV continuum of care.

8) What is the probability that DHWP will get these results?

9) Proposed number of unduplicated clients to be served.

10) Proposed number of service units to be provided.

c. **Quality Improvement Plan (Program Monitoring and Evaluation)**

As previously noted, the federal Ryan White Treatment Extension Act budget is not expected to have major increases in Part A for FY 2010 funding. As funding decreases, it is imperative for Treatment Modernization Act Grantees to consider the costs of services in dispersing Treatment Act funds in relation to their dividends.

As the Grantee moves toward cost and performance based contracting for Ryan White Part A programs, it is critical that funded programs achieve the greatest results at least cost gain. Programs must also be able to document that services complement primary medical care by facilitating access, retention, encouraging adherence, and/or enhancing quality of life.

Provide a narrative description of the program evaluation model inclusive of the following:

1) The identification of a method to monitor program activities and accomplishments;

2) The methods for data collection and analysis, and how findings will be communicated with program staff and fed back into the program's design (how the performance indicators will be measured and tracked, and the program will be evaluated);

3) How the determination of whether outcome objectives have been met;

4) A description of how to improve quality in the delivery of services in your proposed program. Describe how your program will improve the quality of inputs, service delivery, and client outcomes;

Attach a copy of your program monitoring tool in the appendices.

PLEASE NOTE*: Successful applicants will be required to submit a Quality Management Plan to the Grantee within 60 days of their Notice of Grant Award and designate a staff person to participate in quality management activities.*

5) Describe the process for ongoing client feedback regarding the accessibility and appropriateness of services/care;

6) Describe the process for addressing and handling client grievances, and reporting of grievances to the Grantee; and

7) Describe how your program complies, or will comply with the SEMHAC approved Standards of Care (refer to Appendix D).

d. **Collaboration and Coordination**
Specifically describe how the proposed program integrates and coordinates services for your clients with other programs (including prevention and non-Ryan White funded providers) within the continuum of care as well as those required in the *"Points of Entry" agreements* as described below, and how funding mechanisms are coordinated within the applicant agency. Include Memoranda of Agreements as appropriate in your appendices. **Point of Entry agreements must clearly state how the participating organization meets the legislative requirement as defined below.**

Funded entities must maintain appropriate referral relationships with key points of access into the health care system for the purpose of facilitating early intervention (a) for individuals newly diagnosed with HIV disease and (b) individuals knowledgeable of their HIV status but not in care in accordance with **Section 2605 (a) (3)** of the Ryan White Treatment Extension Act of 2009. **PLEASE NOTE**: **Because it is expected that clients receiving services from a Ryan White funded entity will receive appropriate referrals into the health care system, memoranda of agreement between funded Ryan White programs will not be considered as fulfilling the Point of Entry requirement**.

Points of Entry are those likely health care access points frequently used by traditionally underserved HIV positive individuals for medical and social service needs. Nine types are listed in Treatment Act legislation:

Legislatively defined key Points of Entry include:

Public Health Departments	HIV Counseling and Testing Sites
Homeless Shelters	Federally Qualified Health Centers
Emergency Rooms	STD Clinics
Detoxification Centers	Detention Facilities
Substance Abuse/Mental Health Treatment Programs	

e. **Cost-Effectiveness and Cost-Appropriateness**
The Treatment Act requires services to be provided in a coordinated, cost-effective manner that ensures that Part A funds are the payer of last resort for HIV/AIDS services. The Treatment Act [**Section 2605(a) (4)]** stipulates that funds received will not be utilized to make payments for any item or service to the extent that payment has been

made, or can reasonably be expected to be made with respect to that item or service by sources other than Ryan White funds including those available under any State compensation program, insurance policy, or any Federal or State health benefits program or by an entity that provides health services on a prepaid basis.
PLEASE NOTE: The cost effectiveness (on a per unit or per client basis) and cost-appropriateness of programs and services will be closely monitored, supported for continuous improvement and/or modification as appropriate.

1) Discuss how the proposed program addresses this requirement including a discussion of the availability of other funds for the services for which the applicant organization is seeking Part A funds.

2) Provide a description of the cost of providing the proposed service by both unduplicated client as well as unit of service. Discuss the cost appropriateness and the cost

3) Provide a description of the effectiveness of the proposed program. It is expected that providers of similar services may have very different unit costs and subsequent unduplicated client costs. For example, a medical case management program that targets rural or hard of hearing populations may have a much higher unit cost than a medical case management program affiliated with an HIV clinic.

   The purpose of cost discussion is to review the cost range for each proposed program and assess the appropriateness and reasonableness of costs. For example, if home health aides typically cost $30 per hour, but potential providers are twice as expensive, the *cost appropriateness* of this service would be questioned. To determine whether home health aides are *cost effective*, an assessment of whether the cost of producing one hour of service is reasonable relative to the benefits received should be made. Unit cost analysis provides a means of comparing different services when the number of service priorities exceeds available funds.

4) Report on the **Availability of Other Funding** for HIV-related care services within the applicant agency from Federal, State and local private and public sources for the fiscal year that most closely corresponds to the Part A FY 2010 budget period. Applicants should provide this information in narrative form and submit the information in a table format. Include all sources of funds used specifically for this **HIV/AIDS**-related program. Include a summary of your 2010-2011 grants specifying all sources of funds used by the provider in support of each **HIV/AIDS** program for which you are seeking Part A funding. Include the grantor and funded project. Also include a list of other outside funds applied for to support the proposed project and the status of those applications. **Complete forms in Attachment A for each service category for which you are seeking non-competing-continuation Part A funding.**

5) Long-term Strategies for Funding: Provide a narrative description of the long-term strategies for funding this project at the end of the grant period, including other potential sources of funding you plan to pursue.

6) (NEW) Billing for Reimbursable Services: Describe the process for ensuring the practice of billing third party payers for reimbursable services (i.e. Medicaid, Medicare or other third parties).

7) Findings page from the agency's most recent A-133 audit.

8) **Budget and Narrative Justification**

Provide a narrative that explains the amounts requested for each line in the proposed program budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for the one (1) year period - - March 1, 2010 through February 28, 2011. The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. Be very careful about showing how each item in the "other" category is justified. The budget justification MUST be concise. Do NOT use the justification to expand the project narrative.

Proposals that do not include budget justifications as shown in the example in Attachment B will not be accepted. Include the following **Object Class Categories** in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds: name, position title, percent full time equivalency, annual salary, and the exact amount requested.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits must be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items.

Supplies: List the items that the program will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost. In most cases, printing/duplication, rent, utilities, staff development, audit and insurance fall under this category if they are not included in an approved indirect cost rate.

Indirect Costs/Administrative: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities (rent & utilities), depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If the agency does not have an indirect cost rate, one may be obtained by visiting http://rates.psc.gov/. **Agencies must have a federally approved indirect rate and provide evidence of such if funds are allocated to this line item. Indirect/administrative Costs: Indirect/administrative costs are limited to 10% of grant awards, per Ryan White legislative mandates.**

Administrative activities include:

1) Usual and recognized overhead, including established indirect rates

2) Management and oversight of specific programs funded under Part A

3) Other types of program support such as quality assurance, quality control and related activities.

If an entity receiving Part A funds charges for services, it must do so on a sliding fee schedule that is available to the public. Individual, annual aggregate charges to clients receiving Part A services must conform to statutory limitations. The term, "aggregate charges," applies to the annual charges imposed for all such services under Part A of the Treatment Act without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services. This requirement applies to **ALL** service providers from which an individual receives Part A-funded services. The intent is to establish a ceiling on the amount of charges to recipients of services funded under Part A **(Section 2605(e)**). *NOTE: Detroit EMA 2010 poverty level is to be finalized in collaboration with SEMHAC and posted.*

3. Supporting Documentation - Please attach the following documentation as appropriate:

a. Job descriptions of key program staff
b. Listing of governing body members and officers, inclusive of names, addresses, telephone number, and electronic mail addresses
c. Organizational chart showing HIV services and proposed program
d. Memoranda of Agreement and/or existing linkage agreements as referenced in your proposal and/or as required by new legislative requirements under *Points of Entry* requirements.
e. Proof of current agency liability insurance
f. Findings page from the agency's most recent A-133 audit

4. Evaluation Criteria

Proposals are reviewed and scored based upon the evaluation criteria. All applications will be reviewed using an internal review process inclusive of the evaluation criteria listed below as well as FY 2009 performance (as outlined below).

Evaluation Criteria	
POINTS	**CRITERIA**
35	Access to Care Services Implementation Plan
20	Quality Improvement Plan (Monitoring and Evaluation)
25	Collaboration and Coordination
20	Cost-Effectiveness and Cost-Appropriateness Budget
100	**TOTAL POINTS**

FY 2009 PERFORMANCE REVIEW SCORING

a. **Program Accomplishments**

Implementation of program activities/results of outcome objectives as outlined in FY 2009 contractual agreements as evidenced through site visits, programmatic reports, and client-level data reports

b. **Fiscal Accomplishments**

Rate of expenditure and previous history of lapsing funds
Review of internal fiscal controls
Review of audit findings
Timely Budgetary Revisions

c. **Administrative Activities**

Timely submission of written/electronic reports (Financial Status Reports, quarterly progress reports and client-level data reports).

SECTION III

INSTRUCTIONS FOR SUBMITTING THE FY 2010 APPLICATION

DEADLINE & SUBMITTING INSTRUCTIONS

DEADLINE
The deadline for submitting the FY 2010 Part A grant application is **4:00 pm on Friday, January 22, 2010, at the Department of Health and Wellness Promotion, 1151 Taylor, Room 455C.**

PLEASE NOTE:

Late proposals will not be accepted

Proposals not adhering to this guidance will not be reviewed and will be returned to the applicant organization without further consideration

Please submit one (1) original application and three (3) copies. Application must be single sided. Please do not staple or bind the application.

FOR FURTHER INFORMATION

For further information about grant administration or fiscal issues related to Part A applications, please contact Carletta Smiley, Ryan White CARE Services Manager at (313) 876-4954 or SmileyC@detroitmi.gov.

GENERAL INFORMATION FOR ORGANIZING THE APPLICATION

Please adhere to the following:

- Provide A Table of Contents (page 1)
- Number all pages of the application consecutively and place them behind the Table of Contents (i.e., page 2)
- Do not submit double-sided copies
- Do not use photo reduction
- Do not include photos, pamphlets, or over-sized documents

APPENDIX A

FY 2010 PRIORITIES and ALLOCATIONS

PRIORITY RANK	SERVICE Categories	FY 2010 FUNDING
1	Outpatient/Ambulatory Health Services (Primary Medical Care)	$3,292,063
2	Food Bank/Home Delivered Meals	$392,434
3	Medical Transportation	$528,321
4	Medical Case Management	$2,045,814
5	AIDS Drug Assistance Program	$715,049
6	Housing Service	$236,337
7	Emergency Financial Assistance	$304,371
8	Medical Nutrition Therapy	$168,453
9	Mental Health Services	$280,000
10	Psychosocial Support	$81,231
11	Treatment Adherence	$87,201
12	Non-Medical Case Management	$161,154
13	Early Intervention Services	$364,005
14	Oral Health	$428,340
15	Legal Services	$129,635
16	Health Education/Risk Reduction	$75,000
17	Outreach Services	$134,719
18	Home & Community Based Health Services	$250,000
19	Referral	$51,000
	Total	**$9,725,127**

NOTE(S):

The amounts listed above are based on the Planning Council approved allocations per service category and total funds requested within the 2010 Detroit EMA Ryan White Part A application on 10/30/09.

The actual funding available per service category will be established upon receipt of HRSA's Notice of Grant Award and subsequent SEMHAC (Planning Council) approval.

Your agency may write for the entire amount per service category. However, the awarded amount will depend on available funds and the total number of service providers selected.

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICES CATEGORY DEFINITION: AMBULATORY/OUTPATIENT MEDICAL CARE (PRIMARY Medical CARE) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary Medical Care* for the Treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

SERVICE-LEVEL OUTCOME: Reduce morbidity and mortality of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	PATIENT EXCLUSIONS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
65% of clients with HIV will have at least two or more CD4 count and viral load tests performed at least three months apart.	**Numerator:** Number of clients with HIV who had two or more CD4 and viral load tests performed at least three months apart during the measurement year. **Denominator:** Number of clients with HIV who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year of interest.	Patients newly enrolled in care during the last six months of the year.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.	A corrective action plan will be developed if the outcome objective is not met.
75% of eligible female clients with HIV will have a minimum of one Pap screening annually.	**Numerator:** Number of HIV-infected women who were greater than or equal to 18 or reported having a history of sexual activity who had Pap screen screening results documented in the measurement year of interest. **Denominator:** Number of HIV-infected women who were greater than or equal to 18 years in a measurement year of interest, who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year of interest.	1. Women not seen within the measurement year; 2. Women < 18 years old and denied a history of sexual activity; and 3. Women who have had a hysterectomy for non-dysphasia/non malignant indications.		
60% of clients with HIV will receive HIV medication adherence counseling at least every six months.	**Numerator:** Number of clients with HIV who are receiving antiretroviral medication(s) (ARV) who receive at least one medication adherence counseling session every six months (twice annually). **Denominator:** Number of clients with HIV, on ARV therapy who received care for six months, who had a medical and/or who had a medical case management visit; and who had at least one visit in each six month period within the measurement year of interest.	Patients newly enrolled in care during the last six months of the year.	Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICES CATEGORY DEFINITION: AMBULATORY/OUTPATIENT MEDICAL CARE (PRIMARY CARE) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary Medical Care* for the Treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

SERVICE-LEVEL OUTCOME: Reduce morbidity and mortality of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	PATIENT EXCLUSIONS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
75% of clients with HIV will have a medical visit with an HIV specialist at least every six months.	**Numerator:** Number of clients with HIV who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in an HIV setting in each six month period (Jan-Jun, July-Dec) during the measurement year. **Denominator:** Number of clients with HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year of interest.	Patients newly enrolled in care during the last six months of the year.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	A corrective action plan will be developed if the outcome objective is not met

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICE CATEGORY DEFINITION: MENTAL HEALTH services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists and licensed clinical social workers.

Service-Level Outcome: Improve mental health status of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
75% of clients receiving mental health counseling will demonstrate a decrease or stabilization of presenting symptoms.	Client scores on clinical tools completed at intake (baseline) and every three months thereafter until discharge.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.	A corrective action plan will be developed if the outcome objective is not met.
70% of clients on psychotropic medications will attend scheduled psychiatric appointments.	The number and percent of clients who attended at least 70% of scheduled psychiatric appointments within a quarter.		
75% of clients will remain engaged in HIV primary medical care.	The percentage of clients having an HIV primary medical care appointment during the quarter compared to those who attended the appointment. ***NOTE:*** This only for clients who had a scheduled appointment during the quarter and attended at least one appointment.	Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICES CATEGORY DEFINITION: MEDICAL CASE MANAGEMENT SERVICES (INCLUDING TREATMENT ADHERENCE) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client and other key family members' needs and personal support systems. Medical Case Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

SERVICE-LEVEL OUTCOME: Reduce morbidity and mortality of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	PATIENT EXCLUSIONS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
65% of clients with HIV will have at least two or more CD4 count and viral load tests performed at least three months apart.	**Numerator:** Number of clients with HIV who had two or more CD4 and viral load tests performed at least three months apart during the measurement year. **Denominator:** Number of clients with HIV who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year of interest.	Patients newly enrolled in care during the last six months of the year.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	A corrective action plan will be developed if the outcome objective is not met.
75% of eligible female clients with HIV will have a minimum of one Pap screening annually.	**Numerator:** Number of HIV-infected women who were greater than or equal to 18 or reported having a history of sexual activity who had Pap screen screening results documented in the measurement year of interest. **Denominator:** Number of HIV-infected women who were greater than or equal to 18 years in a measurement year of interest, who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year of interest.	1. Women not seen within the measurement year; 2. Women < 18 years old and denied a history of sexual activity; and 3. Women who have had a hysterectomy for non-dysplasia/non malignant indications.		
60% of clients with HIV will receive HIV medication adherence counseling at least every six months.	**Numerator:** Number of clients with HIV who are receiving antiretroviral medication(s) (ARV) who receive at least one medication adherence counseling session every six months (twice annually). **Denominator:** Number of clients with HIV, on ARV therapy who received care for six months, who had a medical and/or who had a medical case management visit; and who had at least one visit in each six month period within the measurement year of interest.	Patients newly enrolled in care during the last six months of the year.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS
HEALTH CARE SERVICES

SERVICES CATEGORY DEFINITION: MEDICAL CASE MANAGEMENT SERVICES (INCLUDING TREATMENT ADHERENCE) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client and other key family members' needs and personal support systems. Medical Case Management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

SERVICE-LEVEL OUTCOME: Reduce morbidity and mortality of PLWH

<table>
<tr><th>EXPECTED CLIENT-LEVEL OUTCOME</th><th>PERFORMANCE INDICATORS</th><th>PATIENT EXCLUSIONS</th><th>DATA COLLECTION METHODS</th><th>IMPROVEMENT PLAN</th></tr>
<tr><td>75% of clients with HIV will have a medical visit with an HIV specialist at least every six months.</td><td>Numerator: Number of clients with HIV who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in an HIV setting in each six month period (Jan-Jun, July-Dec) during the measurement year.
Denominator: Number of clients with HIV who had a medical visit with a provider with prescribing privileges at least once in the measurement year of interest.</td><td>Patients newly enrolled in care during the last six months of the year.</td><td>Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.</td><td rowspan="2">A corrective action plan will be developed if the outcome objective is not met</td></tr>
<tr><td>90% of clients with HIV will have a case management care plan documented and updated at least every six months. (Consistent with MDCH standards of care for medical case management)</td><td>Numerator: Number of clients with HIV with medical case management services who have a medical case management care plan documented and/or updated at least twice a year, less than or equal to six months apart.
Denominator: Number of clients with HIV who had a medical case management visit and who was seen within the measurement year of interest.</td><td>Patients newly enrolled in care during the last six months of the year</td><td>Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater</td></tr>
</table>

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FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICES CATEGORY DEFINITION: MEDICAL TRANSPORTATION SERVICES are conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

SERVICE-LEVEL OUTCOME: Reduce morbidity and mortality of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
90% of **new** clients will experience access to needed medical appointments.	Number of rides requested compared to the number of rides provided during the quarter of interest.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	A corrective action plan will be developed if the outcome objective is not met
90% of **existing** clients will demonstrate continued access to needed medical appointments.	Number of rides requested compared to the number of rides delivered during the quarter of interest.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

Service Category Definition: Emergency Financial Assistance is the provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. Part A and B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in DSS Program Guidance No. 2 (formally Policy No. 97- 02)

Service-Level Outcome: Maintain and/or improve medical stability of PLWH

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
90% of clients who receive emergency assistance with past due utility bills will maintain utility services for at least 90 days after receiving assistance.	Number of clients receiving utility assistance who maintain utilities for a minimum of 90 days following assistance.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater.	A corrective action plan will be developed if the outcome objective is not met
90% of clients who receive EFA will be linked to or remain engaged in primary medical care.	Number of clients who receive EFA services during the quarter will have medical appointments verified.		

APPENDIX B

<table>
<tr><th colspan="4">FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS</th></tr>
<tr><th colspan="4">HEALTH CARE SERVICES</th></tr>
<tr><td colspan="4">Service Category Definition: Housing Assistance is the provision of short – term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing – related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Service-Level Outcome: Decrease homelessness</td></tr>
<tr><th>EXPECTED CLIENT-LEVEL OUTCOME</th><th>PERFORMANCE INDICATORS</th><th>DATA COLLECTION METHODS</th><th>IMPROVEMENT PLAN</th></tr>
<tr><td>90% of clients receiving Housing Assistance will maintain housing stability.</td><td>Number of clients remaining housed at the same address for a minimum of 90 days after assistance.</td><td rowspan="2">Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.

Quarterly chart audit (based on a 10% or a minimum of 30 sample size whichever is greater.</td><td rowspan="2">A corrective action plan will be developed if the outcome objective is not met</td></tr>
<tr><td>90 % of those clients receiving Housing Assistance will be retained in primary medical care services.</td><td>Number of clients who had medical appointments scheduled during the quarter compared to the number of appointments actualized in the quarter.</td></tr>
</table>

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FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICE CATEGORY DEFINITION: Early Intervention Service* include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and test to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures. * **Current Definition reflects Part C language. Part A does NOT include counseling and testing services for HIV.**

Service-Level Outcome: Increase the number of HIV+ individuals who know their status and who are referred for care

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
85% of HIV + client will receive assistance in accessing core/supportive services.	Number of clients successfully linked to services compared to the number of clients who were referred to services during the quarter.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% sample or a minimum of 30 sample size whichever is greater.)	A corrective action plan will be developed if the outcome objective is not met
85% of HIV + clients will be engaged in primary medical care.	The number of clients having an HIV primary medical care appointment during the quarter compared to those who attended the appointment.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS			
HEALTH CARE SERVICES			
Service Category Definition: Non – Medical Case Management includes the provision of advice and assistance obtaining medical, social, community, legal financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments. **Service-Level Outcome:** Decrease barriers to care treatment and support services			
EXPECTED CLIENT-LEVEL OUTCOME	**PERFORMANCE INDICATORS**	**DATA COLLECTION METHODS**	**IMPROVEMENT PLAN**
90% of clients will receive advice and assistance in obtaining core/supportive services (medical, social, community, legal, financial and other needed services).	The number of requests made from clients compared to the number of requests fulfilled.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	A corrective action plan will be developed if the outcome objective is not met

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

Service Category Definition: **Food Bank / Home Delivered Meals** is the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item.

*** Currently the Detroit EMA does not fund services for home delivered meals. Service provision is through the distribution of food vouchers**.

Service-Level Outcome: Stabilize body weight and maintain optimal nutritional health

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
75% of HIV+ clients will improve/stabilize body weight/have improved nutritional status	Number / Percentage of clients demonstrating progress towards their weight management goals (weight gain, loss or maintenance) in follow-up nutritional assessments.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	A corrective action plan will be developed if the outcome objective is not met

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS			
HEALTH CARE SERVICES			
Service Category Definition: Psychosocial Support Services is the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. It includes nutrition counseling provided by a non- registered dietitian, but it excludes the provision of nutritional supplements. **Service-Level Outcome:** Reduce Social Isolation and Improve Self Empowerment			
EXPECTED CLIENT-LEVEL OUTCOME	**PERFORMANCE INDICATORS**	**DATA COLLECTION METHODS**	**IMPROVEMENT PLAN**
85% of clients receiving Psychosocial support services, an increased number / percentage are being retained in primary medical care.	The number of clients having an HIV primary medical care appointment during the quarter compared to those who attended the appointment	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater	A corrective action plan will be developed if the outcome objective is not met.
90 % of clients attending a psychosocial support group will have an opportunity to address their issues.	Increased number / percentage of clients demonstrating the ability to address their concerns within the Psychosocial support group venue through surveys, journaling, evaluation tools or other tools of measurement.		
90% of clients attending a group session will demonstrate an increase in their ability to manage life with HIV/AIDS.	Number / percentage of clients demonstrating an increase of empowerment / self-sufficiency through surveys, journaling, pre/post tests, evaluation tools or other tools of measurement.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS			
HEALTH CARE SERVICES			
Service Category Definition: Legal Services is the provision of services to individuals with respect to powers of attorney, do not resuscitate orders, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White HIV/AIDS Program. **NOTE**: ***It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.*** **Service-Level Outcome: Stabilize life situations for PLWHA**			
EXPECTED CLIENT-LEVEL OUTCOME	**PERFORMANCE INDICATORS**	**DATA COLLECTION METHODS**	**IMPROVEMENT PLAN**
90% of clients will gain or maintain public benefits.	The number of clients with a **favorable** resolution in the quarter compared to the **total** number of concluded cases within the quarter.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.	A corrective action plan will be developed if the outcome objective is not met.
90% of clients will experience a resolution of discrimination and/or breach of confidentiality litigation, **as it relates to services eligible for funding under the Ryan White HIV/AIDS Program.**			
. 95% of clients requesting power of attorney, do not resuscitate orders and estate planning services will receive completed documentation.	The number of **concluded** requests vs. the **total** number of requests for service.	Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	

APPENDIX B

FY 2010
SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICE CATEGORY DEFINITION: **Medical Nutritional Therapy** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical Nutritional Therapy provided by someone other than a licensed / registered dietitian should be recorded under Psychosocial support services.

SERVICE-LEVEL OUTCOME: Maintain and/or improve nutritional status of PLWH.

<table>
<tr><th>EXPECTED CLIENT-LEVEL OUTCOME</th><th>PERFORMANCE INDICATORS</th><th>DATA COLLECTION METHODS</th><th>IMPROVEMENT PLAN</th></tr>
<tr><td>90% of clients will demonstrate an increased knowledge of proper nutrition.</td><td>Comparison of changes between pre/post test at initial assessment and post test at quarterly intervals.</td><td rowspan="3">Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is grater) Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.

Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)</td><td rowspan="3">A corrective action plan will be developed if the outcome objective is not met.</td></tr>
<tr><td>90% of clients will demonstrate an increase in body mass index (BMI) or maintenance of optimum body weight.</td><td>Comparison on baseline BMI/body weight to BMI/body weight at follow-up visits.</td></tr>
<tr><td>90% of clients will demonstrate improved eating habits consistent with nutritional recommendations for persons living with HIV/VIDS as evidenced by a reduction in HIV- related poor nutrition symptoms (e.g., wasting, abnormal lipids, etc.)</td><td>Baseline evaluation of Lipids, Weight, BMI/BCM, and Protein-Energy Malnutrition (PME) compared to quarterly follow-up.

Comparison of scores from pre-survey completed at initial assessment and follow-up visits.</td></tr>
</table>

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FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS
HEALTH CARE SERVICES
SERVICE CATEGORY DEFINITION: HOME & COMMUNITY-BASED HEALTH SERVICES includes skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include: durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. ***NOTE: Inpatient hospital services, nursing homes and other long term care facilities are not included.*** . **SERVICE-LEVEL OUTCOME:** Decrease incidence of hospital/nursing home admission or readmission.

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
75% of clients will experience an improvement of medical condition allowing them to remain at home	Decrease number of days of HIV/AIDS-related hospitalization compared to baseline.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	A corrective action plan will be developed if the outcome objective is not met.
	Improve/ stabilize ability to complete activities of daily living compared to baseline. .		
	. Increase/ stabilize the percentage of clients who remain engaged in ongoing HIV primary care compared to baseline.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS
HEALTH CARE SERVICES

SERVICE CATEGORY DEFINITION: Outreach Services are programs that have as their principle purpose identification of people with unknown HIV disease or those who know their status (i.e. case finding) so that they may become aware of, and may be enrolled in, care and treatment services. **Outreach services do not include HIV counseling and testing or HIV prevention education.** These services may target high – risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

SERVICE-LEVEL OUTCOME: Link newly infected and those who know their status to medical care

EXPECTED CLIENT-LEVEL OUTCOME	PERFORMANCE INDICATORS	DATA COLLECTION METHODS	IMPROVEMENT PLAN
80% of the clients receiving Outreach services, an increased number / percentage are made aware of their HIV status.	Number of referrals made for HIV testing compared to the number of tests actualized.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	A corrective action plan will be developed if the outcome objective is not met.
70% of HIV+ clients who are identified by outreach services will be referred / linked to the care continuum (core and supportive services).	Number of referrals actualized vs. the total number of referrals made.		

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS			
HEALTH CARE SERVICES			
SERVICE CATEGORY DEFINITION: TREATMENT ADHERENCE COUNSELING is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting. **SERVICE-LEVEL OUTCOME:** Improve adherence to complex HIV treatments.			
EXPECTED CLIENT-LEVEL OUTCOME	**PERFORMANCE INDICATORS**	**DATA COLLECTION METHODS**	**IMPROVEMENT PLAN**
90% of clients will become more knowledgeable about treatment adherence issues.	Number / percentage of clients demonstrate an increased knowledge in treatment adherence issues through surveys, pre/post tests, or other evaluation tools of measurement.	Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider. Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)	A corrective action plan will be developed if the outcome objective is not met.
90% of clients will remain engaged in HIV primary medical care.	Number and percent of Clients who had appointments made compared to the number of appointments actualized.		
75% of clients will demonstrate adherence to complex HIV medication regiments / treatments.	The number of dosages missed compared to the number of dosages prescribed.		

DRAFT

APPENDIX B

FY 2010 SERVICE CATEGORY DEFINITION
SERVICE/CLIENT-LEVEL OUTCOMES, PERFORMANCE INDICATOR AND MINIMUM THRESHOLDS

HEALTH CARE SERVICES

SERVICE CATEGORY DEFINITION: Health Education/Risk Reduction (HE/RR) is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information: including information dissemination about medical and psychosocial support services and counseling to help client with HIV improve their health status.

SERVICE-LEVEL OUTCOME:

<table>
<tr><th>EXPECTED CLIENT-LEVEL OUTCOME</th><th>PERFORMANCE INDICATORS</th><th>DATA COLLECTION METHODS</th><th>IMPROVEMENT PLAN</th></tr>
<tr><td>75% of clients who are educated about HIV transmission and how to reduce the risk of transmission.</td><td></td><td rowspan="3">Reported through URS/CAREWare system for each client receiving services from a Ryan White CARE funded provider.

Quarterly chart audit (based on a 10% or a minimum of 30 sample size or whichever is greater)</td><td rowspan="3">A corrective action plan will be developed if the outcome objective is not met.</td></tr>
<tr><td>75% of clients who are educated about available medical and other core/supportive services in the health continuum.</td><td></td></tr>
<tr><td>80% of clients retained in care.</td><td></td></tr>
</table>

Service Category	FY 2010 Directives
HIV Medications	▪ Formulary medicines will be funded only if the projected ADAP shortfall occurs.
Primary Medical Care	▪ The coordination of Community Primary Care Network will be supported. ▪ Services are to be provided in areas where HIV/AIDS epi data demonstrate need in order to increase access to primary care for HIV infected individuals. Ryan White-funded primary care needs to be available for persons in all six counties and Detroit (special emphasis on sub-populatins) ▪ Funded providers must demonstrate that coordination efforts are in place to reach those PLWH who know their status but are not in care and bring them into care (unmet need). ▪ Providers should have someone on staff to seek and find those lose to care; and/or, have a mechanism in place to re-engage those lost to care or partner with EIS and /or Outreach.
Mental Health	▪ Provide services that are not traditionally covered by community mental health. ▪ Providers will partner with Primary Care providers to refer or co-locate services.
Medical Case Management	▪ Case Managers are to attend the MDCH Training. ▪ Creation of peer liaison program to enhance the continuum of care process. ▪ Ensure continuity of care for incarcerated individuals – pre-release (90 days) or recently released.
Medical Transportation	▪ After a six month review there will be a rapid reallocation of Planning Council's budget for Transportation. ▪ Transportation that will support access to appropriate care services. ▪ The type of transportation provided to clients - bus, van or cab - must be based on client need. ▪ Explore alternate transportation options throughout the EMA.
Oral Health	▪ Oral Health will be funded only if the projected shortfall occurs. ▪ Funded through Part B; Clarify covered services and gaps in service.
Substance Abuse Treatment	▪ Other funding streams available in the EMA.
Emergency Financial Assistance	▪ Provide short-term medication assistance, limited to 15 days, along with the essential utilities. ▪ Make financial assistance available for eligible PLWH when no other resources are available.

Service Category	FY 2010 Directives
Outreach	▪ Focus on unmet need in high risk communities according to epi data or other supported information. ▪ Identify Key points of entry ▪ Partner with CBS's agencies and events throughout the EMA. ▪ Utilize peer liaison.
Housing Assistance	▪ Maintain Payment of security deposits, first/last months rent and past-due rents.
EIS	▪ Partner with key points of entry to ensure referral and linkage to care. ▪ Educate staff at key points of entry on how to refer clients into Ryan White and system of care.
Non- Medical Case Management	▪ Provide short-term services/ referrals. ▪ Utilize trained peer liaisons.
Food Bank	▪ Maintain voucher amount allotted to food vouchers. ▪ Consider an increase in allocation based on lapsing dollars. ▪ Fund other providers throughout the entire EMA.
Psychosocial Support	▪ Sign in sheets will be required from all support groups. ▪ Support groups are to evaluate their effectiveness. ▪ Partner with EIS.
Health Education/Risk Reduction	▪ Public awareness campaign in high prevalence zip code areas. ▪ Linkage with referral provider. ▪ Campaign evaluation component
Legal Services	▪ Legal services are to ensure access to Ryan White services.
Treatment Adherence	▪ Utilize trained peer liaison to support improved adherence to medical treatment.
Medical Nutritional Therapy	▪ Increase access throughout the EMA.
Home & Community Based Health Service	▪ Expand scope of services
Information & Referral	▪ Update current resource ▪ Include information targeting special sub-populations

Southeastern Michigan HIV/AIDS Council (SEMHAC)

Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Universal Care Standards

I. DEFINITION: These standards are to be used as a goal for care providers and as a guide for clients. The goal of the Universal Standards of Care is to provide a foundation for the receipt and provision of high quality Ryan White Part A Services.

II. OUTCOME: To ensure that high quality HIV/AIDS care services are provided in the Detroit Eligible Metropolitan Area.

III. ACCESS:

	STANDARD	MEASURE
1.0	**Standard #1 - Services are offered in such a way as to overcome barriers to access and utilization.**	
1.1	All Ryan White Part A services in the Detroit Eligible Metropolitan Area will be provided irrespective of age, physical or mental challenges , creed, criminal history, gender, history of substance abuse, immigration status, marital status, national origin, race, sexual orientation, socioeconomic status, or stage of illness.	• Provider has a written non discrimination policy in place which includes those indicated. • From Patient Satisfaction Survey. • From Client Grievances
1.2	Translator or interpreter services must be made available for those clients who speak English as a second language and other communication challenges, when applicable.	• Policy and Procedure for accessing translator or interpreter services. • Literature available to patients.
1.3	All services will be provided in accordance with ADA Guidelines	• Agency Policy and Procedure
1.4	Established patients, accessing Primary Care services, who telephone for an appointment, will be offered an appointment within 10 days of the desired time.	• Patient Satisfaction Survey results. • Appointment Log
2.0	**Standard #2 - All clients will be informed of the eligibility requirements for services funded through the Ryan White Treatment Modernization Act.**	

STANDARD		MEASURE
2.1	An intake form, which includes all required data, is completed within 5 business days of initial client contact with the agency. The following list is the minimum information to be obtained at intake, in order to assess the client's acuity and appropriate service level. Providers may obtain additional information at intake per individual agency policy. (Asterisks indicate required data entries.) See required data system table. ▪ Date of initial contact/referral ▪ Intake date * ▪ Client name* ▪ Home address ▪ Mailing address if different ▪ County of residence* ▪ Social Security number ▪ Home phone ▪ Alternative contact phone numbers ▪ Communication method to be used for follow-up, confidentiality considerations ▪ Other persons in household and confidentiality considerations ▪ Gender (see URS categories)* ▪ Birth date* ▪ Race/Ethnicity (see URS Categories) ▪ HIV Status-asymptomatic, symptomatic, AIDS diagnosis* ▪ Date tested positive ▪ Medication status-on medication, new to medication, never taken etc. ▪ CD4 count and viral load, if known ▪ Source of medical insurance, if any* ▪ Primary medical care provider or source of medical care ▪ HIV medical care provider or source of HIV medical care* ▪ Primary risk factor (see URS categories) ▪ Housing status-permanently housed, homeless etc.* ▪ Presenting problems and immediate health care needs, if any ▪ Employment status and monthly income ▪ Other sources of income or benefits ▪ Household size & annual income*	• A complete intake form is in client file and was completed within five business days • Required data are entered into the appropriate automated reporting system.

	STANDARD	MEASURE
2.2	All service providers will verify the eligibility of anyone seeking Ryan White funded services. a. In order to be eligible for service, individuals must meet the following: • HIV+ • Residence in the Detroit EMA • Proof of income • Proof of identity b. If not eligible, procedures will be in place to refer clients to appropriate services. c. Insurance Verification • Medicaid or private insurance coverage will be verified.	• Written policies and procedures regarding client eligibility • Proof of HIV status within 30days and eligibility in each client's file • Verification of income status or financial letter of support • Documentation in client record.
2.3	Client self-report of HIV status is documented at the time the client is seeking service(s). As soon as possible, verification of the client's HIV status is obtained to ensure eligibility for HIV medical and support services. Acceptable verification includes at least one of the following: • A copy of the client's seropositive test result, confirmed in accordance with Michigan law; • A signed document from a physician or his/her designee as allowed under Michigan law verifying that the client is HIV positive; or • Lab results at any time during the client's lifetime, that show the presence of the human immunodeficiency virus.	• Verification of HIV status is in client file.
3.0	**Standard #3 - Services will be accessible after normal businesses hours.**	
3.1	All service providers will have written instructions for patients on how to access the provider after hours and on weekends as appropriate.	• Agency policy and procedure.

IV. ADMINISTRATIVE REQUIREMENTS:

1.0	**Standard #1 - Personnel Policy**	
1.1	Providers will have written policies and procedures in place for personnel	• Agency Policy and Procedure
1.2	Agencies will provide staff with job descriptions that address minimum qualifications, core competencies, and job responsibilities	• Copies of job descriptions
2.0	**Standard #2 - Cultural Competence to assist the consumers in receiving services in a culturally sensitive environment**	
2.1	Staff is competent at delivering services to culturally and linguistically diverse populations. This should be reflective of the target population to be served.	• Agency Policy and Procedure • Documentation of cultural competency training
3.0	**Standard #3 - Data Collection**	
3.1	Providers will utilize the appropriate data system that fulfills the reporting requirements for Ryan White Part A	• Data collection system is in place that fulfills the reporting requirements. • Documentation of utilization
4.0	**Standard #4 - Staff Screening**	
4.1	a. Staff providing service to clients shall be screened for appropriateness as follows: i. Personal references ii. Personal interview iii. Written application iv. Criminal background check (for those who work with minors and the elderly) b. Policies and procedures exist for obtaining appropriate clearances on staff and/or volunteers.	• Review of Job description and resume on file • Agency Policy and Procedure
5.0	**Standard #5 - Staff has current licensures, training and experiences necessary to perform services.**	
5.1	Staff are licensed and accredited by appropriate local, state and/or federal agencies if applicable.	• Current license(s) are on file at Provider Agency from local, state and/or federal agencies.

5.2	b. Professional Staff, providing direct service, should have knowledge of the HIV/AIDS disease process, the effects of HIV/AIDS-related illnesses and co-morbidities on patients, the psychosocial effects of HIV/AIDS on patients and their families/significant others, and current strategies for management of HIV/AIDS. c. Volunteers should have HIV/AIDS 101 Training.	• Documentation of all training in personnel file. • Specific HIV/AIDS Training and updates
5.3	Orientation curriculum includes the following items: a. Initial training includes HIV/AIDS basics, health and safety issues (fire & emergency preparedness, hazard protocols, infection control, universal precautions, MIOSHA and HIPAA), confidentiality issues, cultural diversity, role of staff/volunteers and agency-specific policy and procedures. b. New staff hires will begin initial training prior to providing services. c. Administrative/program staff new hires will begin initial training within one month of being hired. c. Staff will be trained regarding the continuum of care for HIV+ persons, especially the function of medical case management and HIV Primary Care, and the process of referring a patient for that service.	1. Documentation of items covered in orientation curriculum in personnel file.
5.4	Continuing Education a. Periodic staff development training for all staff and volunteers as required by licensing authority. b. The agency will require staff attendance at continuing education, professional development opportunities for both HIV/AIDS topics and co-morbidities for best practices.	• Documentation of training
5.5	Experience – HIV/AIDS A minimum of 1 year documented HIV/AIDS work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV/AIDS work experience.	• Documentation of work experience.

5.6	Internal Training Evaluation Staff will complete evaluation of training, and feedback will be used in revision of training material.	• Review of evaluations and training materials indicates compliance.
6.0	**Standard #6 - Professional Behavior**	
6.1	Professional Behavior Staff follows written standards of professional behavior. Specifically, staff is expected to follow code of conduct as described in State licensure or agency policies and procedures.	• Agency policy and procedures • Review of personnel files indicates compliance.
6.2	Staff Supervision Administrative and clinical/direct services program staff are supervised by experienced and licensed supervision.	• Agency Policy & Procedure. • Review of personnel files indicates compliance.
6.3	On at least an annual basis, staff and supervisors receive a performance evaluation.	• Personnel file contains a current performance evaluation.
7.0	**Standard #7 - Safety and Emergency Procedures**	
7.1	Services are provided in facilities that are clean, comfortable, and free from hazards.	• Site visit by Grantee.
7.2	Agency will ensure that policies and procedures are in place that ensure the safety of clients and staff including: • Physical Plant Safety • Emergency Procedures • Medical/Health Care • Infection Control and Transmission Risk • Health and Safety • Crisis Management • Risk Assessment • Accident / Incident Reporting	• Agency Policy & Procedure.

7.3	Staff follows recommended Occupational Safety and Health Administration (OSHA) and state public health practices for infection control for care of immunologically impaired individuals and is in compliance with protocols on management of occupational exposure to HIV/AIDS	• Personnel file contains a signed statement acknowledging that OSHA guidelines were reviewed and that the employee understands agency policies and procedures.
7.4	Direct care personnel will have current certification in First Aid/CPR.	▪ Documentation in Personnel files.

V. TREATMENT/SERVICE PLAN:

1.0	**Standard #1 - All Clients, receiving ongoing services, will have a treatment/service Plan in place.**	
1.1	Service Plan Service plans are developed jointly with the staff and client and must include: • Statement of service goal(s) • The plan of intervention and implementation • Mechanism for review	• Documentation in client file

VI. PATIENT'S RIGHTS AND RESPONSIBILITIES:

1.0	**Standard #1 - Clients rights will be honored and they will be advised of their responsibilities.**	
1.1	a. Agencies will provide clients with a written statement outlining their rights. The statement should include: • Nature of services offered. • Conditions for service • The ability to terminate service(s) at any time. • Transfer and closing procedures • Consumer progress review • Access to treatment files b. Agencies will provide clients with a written statement outlining their responsibilities. The statement should include: • The consumer's responsibility for scheduling appointments • Policy and procedure prohibiting drugs, alcohol and weapons on the	• Client file • Agency policies and procedures

	premises. • Calling the provider to cancel or reschedule if an appointment cannot be kept. c. The agency must document that clients are informed of the above.	
1.2	Intake forms will be completed and client will sign for receipt of the following: • Agency eligibility criteria • Release(s) of Information • Consent to Receive Services • Grievance process • Client rights and responsibility • HIPAA and confidentiality	• Agency policy and procedure • Client file
1.3	Provider will have a written policy regarding missed appointments and consumer discharges on file.	• Written policy on file.

VII. CONFIDENTIALITY:

1.0	**Standard#1 - All service providers will maintain clients' confidentiality in accordance with State and Federal laws.**	
1.1	All provider staff will be trained on confidentiality and HIPAA (Health Insurance Portability and Accountability Act) and will sign confidentiality statements.	• Personnel files
1.2	All patient records at facilities are maintained in a secure location.	• Records are stored in a locked room or cabinet and electronic files are secured by personnel. • Authorized personnel responsible for records are physically present when records are opened or unlocked.
1.3	Providers will have policies and procedures in place that define the process for third party requests for medical records in accordance with HIPAA Rules.	• Signed and dated Release of Information maintained in patient's file.

VIII. CONTINUITY OF HIV SERVICES:

1.0	**Standard #1 - All Ryan White Funded service providers will establish relationships in order to build a coordinated continuum of HIV/AIDS services available to clients in order to address multidisciplinary needs in a seamless manner.**	
1.1	All service providers will inform current and new clients of the various HIV/AIDS services available in the Detroit Eligible Metropolitan area.	• Provider information (i.e., flyers, handouts, literature and the User Friendly Manual)
1.2	All service providers will have a referral system in place and with a tracking mechanism.	• Documentation of referrals made and referrals kept – site visit findings. • Documentation of Memorandum of Understanding (MOU), Memorandum of Agreement (MOA), and Point of Entry Agreement (POE) on file

IX. CLIENT SATISFACTION:

1.0	**Standard #1 - All service providers will assess and monitor their clients' satisfaction at least twice a year.**	
1.1	All service providers will conduct a client satisfaction survey at least twice a year and will examine the delivery of services in terms of quality, accessibility, and respect.	• Reports of customer satisfaction survey to Grantee. • Customer Satisfaction Survey. • Surveys include but not limited to: ✓ Provider staff ✓ Treatment received ✓ Waiting time ✓ Facility accommodations
1.2	All service providers will develop a process to review the results of client feedback with all staff. Appropriate staff will respond to areas that need improvement.	• Quality Improvement Plan or Policy
2.0	**Standard #2 - All service providers will have client grievance and complaint procedures in places**	
2.1	All service providers will have an objective process to handle clients' grievances and track the outcome.	• Grievance policy and procedure. • Grievance resolution tracking tool.

2.2	All service providers must monitor client complaints which are not appropriate to the grievance procedure and must address the complaints in a timely manner.	• Complaint policy. • Complaint resolution tracking tool.

X. QUALITY IMPROVEMENT:

1.0	**Standard #1 - All providers will have a continuous Quality Improvement Program.**	
1.1	Agency must have a Quality Improvement Program with supported activities such as chart audit, peer-to-peer review, data collection etc. Agency must maintain documentation of the following: • Utilization reviews • Most recent site visit by the grantee • Corrective Action plans as needed • Data and narrative reports to the grantee • Care plan review	• Agency Policy & Procedure. • Documentation in the agency's Quality Plan
1.2	Programs are based on best practices and consistent with local, state and national standards.	• Agency Policy & Procedure.
1.3	Measure and report patient outcomes utilizing data and outcome measures approved by the Grantee as set forth in the programs implementation plans.	• Documentation in the agency's Quality Plan • Quarterly Reports
1.4	A minimum of one quality initiative per year	• Documentation in the agency's Quality Plan

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard

Service Category: Medical Case Management (including treatment adherence)

I. **DEFINITION OF SERVICE :** Medical Case management services (including treatment adherence) are a range of client- centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HI V/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client- specific advocacy and/or review of utilization of services. This includes all types of medical case management including face-to-face, phone contact, and any other forms of communication.

II. **OUTCOMES:** Reduce the barriers to services for PLWH

III. ADMINISTRATIVE

	STANDARD	MEASURE
1.0	**Standard #1 - All case managers and the direct supervisor of medical case management clinical staff will meet the basic education and credential requirements.**	
1.1	The minimum education and/or experience requirements for case managers and their direct supervisor is a RN (with a Baccalaureate Degree in Nursing preferred), or Bachelor of Social Work (BSW) degree, or other related health or human service degree from an accredited college or university. Alternatively, related direct client service experience which has been performed under the supervision of a human services professional for a period of two (2) years of full time service regardless of academic preparation can be substituted.	• A copy of the diploma, credentials, and/ or proof of two years of full time service in an alternatively related experience will be in each case manager's and direct supervisor's file.

1.2	All case managers must be HIV/AIDS Case management Certified within twelve months of beginning service.	• Verification of HIV/AIDS Case Management Certification will be in each case manager's file.
1.3	Direct supervisors of case managers must be HIV/AIDS Case Management Certified within three to six months of beginning employment.	• Documentation on file
1.4	All case managers and direct supervisors of medical case management clinical staff must be re-certified every 2 years as per state standards.	• Documentation on file

IV. MEDICAL CASE MANAGEMENT PROVISION OF SERVICE

	STANDARD	MEASURE
1.0	**Standard #1 - Intake - All clients who qualify for medical case management Services will participate in the intake process.**	
1.1	The intake process should begin at the initial contact with the prospective client and be completed within 5 business days.	• Documentation in clients' files.
1.2	An acuity screening scale worksheet is utilized and appropriateness for medical case management services is determined and documented.	• The client acuity scale worksheet is in the client file and the score and assigned acuity level are entered into the appropriate automated reporting system
1.3	All clients who do not qualify for medical case management services will be referred to the appropriate service.	• Policy and Procedure for referring to appropriate service.
1.4	Refer to Section 2.1 of the Universal Standards for specific information on client intake and intake data requirements	• A complete intake form is in client file and was completed within five business days • Required data are entered into the appropriate automated reporting system.
1.5	Supervisors have 3 business days in which to assign a case manager.	• Documentation in the client's file.
1.6	Immediate health care related and other emergent needs will be identified at any time and have appropriate actions taken.	• Documentation in the client's file of action taken to resolve immediate health care related and other emergent needs.

	STANDARD	MEASURE
1.7	A list of medical case management resources is provided to each client.	• Receipt of resources is documented in client's file
2.0	**Standard #2 - Assessment / Re-assessment – Each client of Medical case management Services will participate in an interview to assess their bio-psychosocial needs.**	
2.1	The assessment is to be conducted face to face and at a location that is mutually acceptable to the client and the case manager.	• Documentation in the client's file.
2.2	A face-to-face biopsychosocial assessment is to be conducted within 30 days of intake and a re-assessment at least every 60 days and include an assessment of: • Life area needs • Medical History • Current medical care • Current medications • Adherence counseling and educational needs • Assessment of adherence and medication readiness • Need for prevention counseling • Knowledge of partner counseling and referral services • Michigan law regarding informing sex and needle-sharing partner of HIV status • Need for assistance with disclosure	• There is documentation in the client file that a biopsychosocial assessment was completed within 30 days of intake. • There is documentation in the client file that life areas and other items listed under this standard were assessed. • The completed adherence assessment form is included in the client file. • A completed assessment tool or another prevention assessment tool is in the client file. ▪ Documented in data system through a service record (assessment) and progress case notes. ▪ There is documentation in the client file that a re-assessment is conducted at least every 60 days for those remaining in medical case management
3.0	**Standard #3 - Service Plan Development – Each client of medical case management services will participate in developing a service plan.**	

	STANDARD	MEASURE
3.1	A client centered service plan is developed collaboratively with the client and documented within 30 days of intake and will include: ▪ A description of the problem(s), challenge(s) or need(s) ▪ Goals for resolving each problem, challenge or need ▪ Action steps to be taken to accomplish each goal ▪ Time frames in which services are to be provided ▪ Documentation of who will provide the service ▪ An agreed upon plan for follow-up ▪ Barriers to accomplishing the goals if applicable; and ▪ Dated signatures of the client, case manager and when applicable the case manager's supervisor	• There is documentation in the client file that a service plan was completed within 30 days. • There is documentation in the client file that identifies all areas in the standard • Documentation in the data system through a service record (service planning) and progress/case notes. • Documentation in the client's file of action taken to resolve immediate health care related and other emergent needs.
3.2	The service plan will be reviewed on an as needed basis determined by the case manager and/or client and will be updated at least every (6) six months coinciding with the reassessment. The signature of the client is not required on the updated service plan, however, the case manager should document that the updated service plan was discussed with the client.	• There is documentation in the client file that the service plan was reviewed and updated where necessary • There is documentation in the client file that the service plan was discussed with the client. • Documented in the data system through a service record (reassessment) and in case notes.
3.3	Additional signed release of information forms are obtained, as necessitated by the service plan that were not obtained at intake.	• There are releases of information forms in file that are signed and dated by the client.
3.4	Client must receive assistance, if needed, to assure ongoing access to medical care, treatment and other services.	• Documentation in the client file and in the appropriate data system and case or progress notes.
4.0	**Standard #4 - Service Plan Coordination, Monitoring and Follow Up – Clients will be assisted with accessing and retaining services.**	
4.1	Contact and follow-up with client's medical providers and other service providers is ongoing.	• Documentation in the client file.
4.2	Results of CD4 and viral load must be documented in the client file at a minimum of every 6 months, unless the client refuses laboratory testing.	• Client file and data system contain documentation of laboratory results, refusal of laboratory testing, and reason for refusal.
4.3	Genotype testing where applicable	• Date of genotype test is documented in client file and data system.

	STANDARD	MEASURE
4.4	A letter from the medical case management agency must be sent to the client's physician informing the physician that the client *is* receiving medical case management services through the agency.	• A consent form and copy of the physician letter is included in the client File.
4.5	Quality indicators must be collected on all clients every 6 months and documented in the data system.	• Documentation in the data system.
4.6	The case manager has appropriately signed and dated all notes unless using the appropriate data system to record notes.	• Documentation in client file and data system..
4.7	The documentation must indicate the need for continued medical HIV case management services.	• Documentation in the client file and/or data system
5.0	**Standard #6 - Discharge – A systematic process shall be in place to guide discharge from medical case management services and transition to other agency services or providers as appropriate.**	
5.1	A discharge from medical case management services **shall** occur if: • Verification of HIV positive status cannot be obtained within thirty business days after enrollment in services; • Verification that the client is an affected person of someone who is HIV + and in need of this persons support is unable to be obtained; • The client and/or client's legal guardian has requested the case be closed; death of client.	• Discharge summary in client's file
5.2	▪ Relocation of the client outside of the provider's geographic service area ▪ Inability to contact the client for 90 days or more ▪ The client's needs are more appropriately addressed through other agencies; or ▪ The client exhibits act of abuse of agency staff, property or services.	• Documentation in client file and data system

STANDARD		MEASURE
5.3	Clients who are discharged for reasons other than death, relocation or referral to other agency services may be placed on "inactive" status for a period of up to 12 months.	• Inactive status and date will be recorded in the data system on Provider custom tab.
5.4	If the client returns to the agency within a twelve (12) month period, an evaluation and update of the life areas should be performed and documented in the client file. Re-enrollment into medical HIV case management should not be repeated.	• Current status and date will be recorded in the data system on Provider custom tab.
5.5	If there has been no client contact for a twelve (12) month period, the client's file should be considered "closed." If the client re-enrolls into medical case management, these standards apply in their entirety.	• Current status and date will be recorded in the data system on Provider custom tab.
5.6	When possible, all clients need to be notified that they are being discharged from medical case management services.	• Documentation of client's notification of discharge or attempts made to notify client of discharge will be maintained in the progress notes of the client's file. If phone contact is not possible and the provider has the client's written permission to mail correspondence to them, a letter is to be sent to the client notifying them of their pending discharge. A copy of this letter is to be maintained in the client's file
5.7	Within fourteen days of the final decision to terminate services, the discharge summary is prepared and signed by the case manager, reviewed and countersigned by the medical case management supervisor.	• Documentation of client discharge will be done in the discharge summary maintained in the client's file.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard

Service Category: Non-Medical Case Management (Formerly Client Advocacy)

I. **DEFINITION OF SERVICE:** Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

II. **OUTCOME**: Decrease barriers to care treatment and support services.

III. ADMINISTRATIVE:

	STANDARD	MEASURE
1.0	**Standard #1 - All advocates and the direct supervisor of advocacy will meet the basic education and credential requirements.**	
1.1	The minimum education and/or experience requirement for an advocate is a high school diploma or GED. Related direct client service experience which has been performed under the supervision of a human services professional for a period of one (1) year of full time service regardless of academic preparation may be substituted.	• A copy of the employee's diploma, credentials, and/ or proof of one year of full time service in an alternatively related experience will be in each advocate's employee file.
1.2	All advocates will attend basic HIV knowledge training within six months of employment.	• Verification of basic HIV knowledge training will be in each advocate's employee file for those who have obtained six months of employment
1.3	All advocates will attend a minimum of four (4) hours of HIV related education per year that has been approved by the City of Detroit Department of Health & Wellness Promotion.	• Documentation of this training requirement will be maintained in the advocate's file.

STANDARD		MEASURE
1.4	The education and/or experience requirements for the direct supervisor of advocacy is a RN (with a Baccalaureate Degree in Nursing preferred), or Bachelor of Social Work (BSW) degree, or other related health or human service degree from an accredited college or university. Related experience can be substituted which has been performed under the supervision of a human service professional for a period of three (3) years of full time service, regardless of academic preparation.	• A copy of the employee's diploma, credentials, and/ or proof of three years of full time service in an alternatively related experience will be in each supervisor's employee file.
1.5	Direct supervisors of advocates must obtain HIV/AIDS case management certification within 3 months or the first available training opportunity from beginning of employment	• Verification of HIV/AIDS Case Management Certification will be in each direct supervisors file.
1.6	All direct supervisors of advocates will remain HIV/AIDS Case Management certified. Retention of HIV/AIDS Case Management Certification is defined as attending a minimum of four hours of HIV related education per year.	• Verification of retention of HIV/AIDS Case Management Certification will be in each supervisor's employee file.

IV. ADVOCACY SCREENING:

STANDARD		MEASURE
1.0	**Standard #1 - All clients requesting access to Advocacy Services will be screened for appropriateness as determined by presenting needs.**	
1.1	All clients will be screened for advocacy and will receive services as appropriate.	• Documentation in client's file.
1.2	All HIV+ clients who are not appropriate candidates for advocacy will be assisted.	• Agency will have policy and procedures for referral to appropriate service.

V. ADVOCACY PROVISION OF SERVICE

STANDARD		MEASURE
1.0	**Standard #1 - Problem identification and resolution.**	

STANDARD		MEASURE
1.1	Initial problems or needs are identified and prioritized by the client and the advocate during their first contact, if possible, or at an agreed upon time scheduled between the client and advocate.	• Documentation of the client's initial problems or needs will be maintained in the client's file.
1.2	An action plan is mutually agreed upon between the client and advocate to address the initial problems or needs.	• Documentation of the actions taken, or need to be taken to resolve the client's initial problems or needs will be maintained in the client's file.
1.3	All required forms needing to be completed for the client to receive advocacy assistance will be obtained at the first face to face contact between the client and advocate, if possible, or as agreed upon between the client and the advocate.	• Documentation in client's file according to agency's policy and procedures
1.4	The advocate will assist the client until their initial problem or needs have been addressed.	• Documentation of services rendered will be maintained in the progress notes of the client's file.
1.5	If the client signed an approval for follow up, follow up must be done by the advocate within thirty days to determine the outcome.	• Documentation in client's file according to agency's policy and procedures
1.6	If additional problems or needs develop it is the responsibility of the client to notify the advocate for any additional assistance.	• Documentation of additional problems or needs will be maintained in the client's file.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Early Intervention Services

I. **DEFINITION OF SERVICE:** Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

II. **OUTCOME:** Increase the number of HIV+ individuals who know their status and who are referred for care

III. **CLIENT SERVICE REQUIREMENTS:**

	STANDARD	MEASURE
1.0	**Standard #1 - Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.**	
1.1	Program Information Broad-based dissemination of information regarding the availability of services. EIS workers shall establish contacts with HIV testing sites and other places where high risk individuals might congregate.	• Agency has a written annual dissemination plan. • Memorandums of agreements with agencies in areas where high risk individuals may congregate.
1.2	Staff Availability Staff are accessible by phone or pager during work hours	• Review agency policy
1.3	**Newly diagnosed or those lost to care will receive immediate access to HIV primary medical care.**	• Agency Policy and Procedures
	STANDARD	**MEASURE**
2.0	**Standard #2 - Services are part of the coordinated continuum of HIV/AIDS services.**	
2.1	Services must be consistent with the most current published CDC guidelines for counseling, testing and referral (http://www.cdc.gov/hiv/ctr/default.htm).	• Documentation in client record, training and certification of staff and agency policies and procedures.

	STANDARD	MEASURE
2.2	EIS workers may work with individual clients for a maximum of six months. After this time clients will be referred to primary care, medical or non-medical case management services.	• Documentation in client record.
2.3	Services to be provided include: • HIV testing • Information on living with HIV disease and managing therapeutic regimens • Counseling on modifying behaviors that compromises one's or other's health status • Procurement of identification documentation necessary for eligibility • Referrals to appropriate prevention and risk reduction programs and to primary care or case management for those testing positive • Referrals to prevention programs for high-risk individuals who test negative	• Documentation in client record of linkages made • CPCDMS client report • Documentation in client file
2.4	Agency must have the capability to obtain appropriate lab work for clients as necessary to implement program	• Agency Policy and Procedure

IV. ADMINISTRATIVE REQUIREMENTS:

1.0	**Standard #1 - Staff HIV/AIDS knowledge is based on solid training and experience.**	
1.2	Ongoing Education After the first year of employment, EIS workers will obtain a minimum of fifteen (15) hours per year additional education and/or training offered by the designated RW Provider.	• Documentation of continuing education in personnel file.
1.3	Requirements and Experience EIS workers must have a minimum of a two (2) year degree and/or one year of experience.	• Documentation of education and experience in the personnel file.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Food Bank-Delivered Meals

I. **DEFINITION OF SERVICE:** Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

II. **OUTCOME:** Stabilize body weight and maintain optimal nutritional health

III. ASSESSMENT OF NEED:

	STANDARD	MEASURE
1.0	**Standard #1 – Assess the need of each client**	
1.1	The provider will conduct an ongoing financial assessment of need.	• Agency policy and procedure • Client File
1.2	All clients will be referred to the nutritionist	• Agency policy and procedure • Client file

IV. CONTINUED SERVICES:

	STANDARD	MEASURE
1.0	**Standard #1 - Measuring Progress**	
1.1	Client progress towards weight management goals will be reflected in follow-up nutritional assessments	• Client file

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Home & Community Based Health Care

I. **DEFINITION:** Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

II. **OUTCOMES**: Decrease incidence of hospital/nursing home admission or readmission.

III. ADMINISTRATIVE:

	STANDARD	MEASURE
1.0	**Standard #1 - All home care providers will meet the education and credentialing requirements for providing the service.**	
1.1	Providers of home health care will meet the credentialing requirements for appropriate staff needed in order to provide home care.	• There is documentation on site of applicable licensor and/or accreditation for agency providing the service.
1.2	Agency staff will have current licensor and/or certifications as required by the State of Michigan.	• Documentation is maintained in personnel files of licenses and/or certifications which may include CPR.

IV. HOME HEALTH CARE STANDARDS OF PRACTICE:

	STANDARD	MEASURE
1.0	**Standard #1 - All Part A funded home health care providers will adhere to generally accepted standards of practice for providing home care.**	

STANDARD		MEASURE
1.1	Core Elements of Home Health Care may include: • Order from client's physician • Home Assessment regarding need for service and physician order for service. • Set up care plan with client. • Assess patient's understanding of HIV disease • Assess overall home situation and needs so that appropriate referrals can be made. • Teach Universal Precautions and Prevention of Transmission *to* staff.	• Documentation will be in the client's file.
1.2	Requirements of reauthorization include: • Physicians must certify reauthorization of services every 60 days with a maximum of 90 days of client service. • Reauthorization decisions must be made in conjunction with the case manager and physician.	• Documentation in client file.

V. HOME HEALTH CARE SERVICE COORDINATION AND DELIVERY :

STANDARD		MEASURE
1.0	**Standard #1 - Services are a part of the coordinated service with physician and Part A Case Manager**	
1.1	Clients must be enrolled into Part A Case Management services within 30 days of admission to service if they are not already enrolled.	• Documentation in client's file.
1.2	Home Health Care staff will follow plan of care and order from the client's physician.	• Documentation in client's file.
1.3	Service reviewed with home health providers and physician regarding progress and continued need for service.	• Documentation in client's file.
2.0	**Standard #2 - Specialized Care**	

STANDARD		MEASURE
2.1	Order from client's physician or referral regarding need for specialized care.	• Documentation of physician order or referral regarding client need.
3.0	**Standard #3 - Discharge**	
3.1	Complete Discharge Summary that indicates services completed and client progress	• Documentation of Discharge Summary in the client file

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Housing Services

I. **DEFINITION OF SERVICE:** Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

II. **OUTCOME:** To assist in bringing individuals into care and retaining them in care

III. PROCESS STANDARDS:

	STANDARD	MEASURE
1.0	**Standard #1 - Service Eligibility Criteria**	
1.1	Agency has eligibility requirements for services available upon request	• Agency policy and procedure
1.2	Consumer's eligibility will include: Universal Standards Items Certification of Need for Emergency Housing for the Purposes of Medical Care Consumer must have current Case Management Assessment and Service Plan	• Client file • Agency Policy and Procedure
2.0	**Standard #2 - Services are part of the coordinated continuum of HIV/AIDS services.**	

	STANDARD	MEASURE
2.1	Referrals Agency receives referrals from a broad range of sources (client's case manager for Housing Coordination) according to HRSA policy 99-02 and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals made and follow thru completed by client.
2.3	Housing Assessment The comprehensive client assessment will include an evaluation of the client's housing needs, strengths, resources, limitations and projected barriers to service at time of intake.	• Documentation in client file.
2.4	Housing Service Plan An initial service plan signed by client, housing coordinator and case manager (if appropriate) will be completed at time of intake and updated as needed.	• Documentation in client file on the housing service plan or agency's equivalent form.
2.5	Progress Notes All coordination activities, including but not limited to, all contacts and attempted contacts with or on behalf of clients are documented in the client file.	• Legible, signed and dated documentation in client file.
2.6	Client Closure A summary progress note is completed within three (3) days of closure.	• Documentation in client file.
3.0	**Standard #3 - Progression/Discharge**	
3.1	Consumers will be referred for long term housing benefits, if applicable or necessary, upon expiration of emergency services	• Referrals made and follow thru completed by client.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Legal Services

I. **DEFINITION OF SERVICE::** Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

II. **OUTCOME:** Stabilize life situations for PLWH

III. **ACCESS**

	STANDARD	MEASURE
1.0	**Standard #1: Services are offered in such a way as to overcome barriers to access and utilization.**	
1.1	Services are provided at minimal cost to the client. In the case of HIV infected individuals with an income greater than 100% of the official poverty line, the provider will impose a charge on each individual or the provision of services according to a schedule of charges.	• A copy of the agency policy and procedure regarding a sliding fee scale. • Copy of retainer agreement with client, including cost of service, is on file. • Documentation that eligibility standards are met is in file.
2.0	**Standard #2: Client and family participation in care decisions is maximized.**	
2.1	Clients are kept informed and work together with staff to decide the objective of the representation, to make decisions regarding the case, and to achieve goals in a timely fashion.	• Copy of retainer agreement between client and agency is in client file. • Data from file shows client is kept informed and is involved in making decisions about the case and that goals are completed in a timely fashion.
3.0	**Standard #3: Services utilize effective management practices generally accepted within the legal profession.**	
3.1	Legal work is supervised to ensure that services are delivered correctly and are timely.	• Legal service providers hold regular case acceptance and case review meetings.

STANDARD		MEASURE
		• Regular staff evaluations are conducted and on file.
3.2	Legal service providers make appropriate referrals when necessary.	• Client service reports show number of referrals made. • Agency monitors logs for appropriateness of referrals.
4.0	**Standard #4: Providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV/AIDS. Legal service providers will develop trustful relationships wherein personal and social issues related to seeking and receiving HIV care may be successfully resolved.**	
4.1	Services are provided in a sensitive, compassionate, non-judgmental, and comprehensible manner	• Client satisfaction survey indicates compliance.
4.2	Staff are trained and knowledgeable in the law and have awareness of HIV/AIDS-related issues and concerns.	• Attorneys are licensed to practice law. • Staff has access to updated HIV/AIDS information.
5.0	**Standard #5: Providers uphold client rights**	
5.1	All information disclosed by client is confidential. It will not be released to anyone without client permission except as permitted or required by rules of professional conduct or by law.	• Written retainer agreement includes confidentiality assurance.

Southeastern Michigan HIV/AIDS Council
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Mental Health Services

I. **DEFINITION:** Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

II. **OUTCOME:** Improve mental health status of PLWH.

III. ADMINISTRATIVE:

	STANDARDS	MEASURES
1.0	**Standard #1 - Staff/Training**	
1.1	HIV Experience Two years experience in HIV or another communicable disease preferred.	• Documentation of experience is maintained by the agency in each staff's personnel file.
1.2	Family Counseling Experience Professional staffs must have two years experience in family counseling if providing services to families.	• Documentation of experience is maintained by the agency in each staff's personnel file.
1.3	Ongoing HIV Training Staff must receive training in HIV annually.	• Documentation of training is maintained by the agency in each personnel file.

IV. CONTINUUM OF CARE AND SERVICE DELIVERY:

	STANDARDS	MEASURES
1.0	**Standard #1 - Intake**	

<table>
<tr><th></th><th>STANDARDS</th><th>MEASURES</th></tr>
<tr><td>1.1</td><td>Intake information must include:
• Demographic information
• Insurance information
• Employment and income status
• Alcohol and drug history and current usage
• HIV status
• Presenting problems
• Recipient rights form (when face to face)</td><td>• Documentation of completed intake form in client’s file.</td></tr>
<tr><td>1.2</td><td>Using the appropriate tools, a comprehensive psycho-social assessment of the individual will be conducted within 30 days from intake which may include:

• Primary medical care status
• Training
• Military service
• Medications
• Mental health and psychiatric history
• Previous mental health providers
• Legal history
• Family history
• Physical, emotional and/or sexual abuse history
• Sexual and relationship history and status
• Leisure and recreational activities
• General psychological functioning
b. Within 30 days of the assessment a Psychiatric evaluation of the individual will be conducted</td><td>• Documentation of comprehensive psycho-social assessment in client file
• Documentation of diagnosis in client’s file.</td></tr>
<tr><td>2.0</td><td colspan="2">Standard #2 - Care and Provider Continuity</td></tr>
</table>

	STANDARDS	MEASURES
2.1	Timely Service Clinical services will be provided within 10 business days	• Agency Policy and Procedure • Documentation in client record
2.2	Continuity of Care The agency will provide mechanisms for referrals to services such as: • Day programs • Day hospitals • Substance-abuse programs • Inpatient psychiatric units • Inpatient medical units and • Chronic-care units (nursing homes). • Provisions will be made for off-site care if clinically necessary.	• Documentation in client record
2.3	Progress Notes • Progress notes are completed in accordance with JCAHO standards.	• Documentation of progress notes in client's file.
2.4	Discharge Planning Discharge plan is completed no later than 60 days with no client contact and will include: • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Circumstances of discharge • Discharge plan • Staff authentication, in accordance with current JCAHO standards • Date	• Documentation in client file.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Medical Nutrition Therapy

I. **DEFINITION OF SERVICE:** Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

II. **OUTCOME:** Maintain and/or improve nutritional status of PLWH.

III. **ADMINISTRATIVE:**

	STANDARD	MEASURE
1.0	**Standard #1 - All nutritional service providers are licensed/registered dietitians**	
1.1	Written policies and procedures exist concerning the frequency of counseling that can be expected.	• Policies and procedures on file

I. **ACCESS:**

	STANDARD	MEASURE
1.0	**Standard #1 - Clients will experience easy access to services**	

	STANDARD	MEASURE
1.1	a. Eligible clients are contacted within 5 business days b. Once initial contact is made with the client, an initial appointment will be made within 20 business days from the contact date. c. Nutritional services are provided in a manner that overcomes barriers to access and utilization, including efforts to accommodate linguistic and cultural diversity.	• Policies and procedures on file

II. NUTRITIONAL COUNSELING STANDARDS OF PRACTICE:

1.0	**Standard #1 - Nutritional counseling will be conducted in compliance with recognized professional standards.**	
1.1	a. Nutritional plans contain medically and culturally relevant recommendations developed by a Registered Dietitian (RD) that adhere to the American Dietetic Association's guidelines. b. Clients are referred to nutritional counseling by primary medical care providers and through food banks and other avenues. c. Clients with HIV, and/or family members(s) identified as needing nutritional counseling, receive nutritional-counseling plans that are integrated into the primary health care plans. Nutritional counseling adheres to the professional standards.	• Agency Policy & Procedure. • Documentation in Client's file.

Southeastern Michigan HIV/AIDS Council
Ryan White Part A - Care Standard
for the Detroit Eligible Metropolitan Area (EMA)
Service Category: Outreach Services

I. DEFINITION OF SERVICE: Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

II. OUTCOME:

1. Increase the number of clients who know their HIV status and receive HIV related medical care and/or evaluation.
2. Attempt to reduce the number of patients lost to follow up.
3. Reduce the number of barriers experienced by out-of-care clients in accessing HIV related medical care and/or evaluation

III. PUBLIC EDUCATION AND CONTINUUM OF CARE:

	STANDARD	MEASURE
1.0	**Standard #1: Program Information to educate the public regarding HIV and the availability of HIV related services**	
1.1	a. Broad-based dissemination of information regarding HIV and the availability of services. b. Outreach workers shall establish contacts with HIV testing sites, hospitals, substance abuse centers, Case Management Agencies, points of entry as defined by the Ryan White Treatment Modernization Act and	• Yearly outreach activity plan in place. • Documentation which demonstrates broad-based dissemination of information i.e. Memoranda of Agreements (which may include non-Ryan White funded entities.)

	STANDARD	MEASURE
	other sources for at-risk and HIV infected clients.	
2.0	**Standard #2: Data Collection to capture data elements which demonstrate efficacy of services**	
2.1	a. The provider will collect data to document the number of HIV+ individuals identified and contacted as being lost to follow-up. b. The provider will also collect data on the number of HIV + persons entering care.	• Documented number of HIV + contacts. • Documented number of HIV + contacts entering care.
3.0	**Standard #3: Client Intake to identify the in-care status of each consumer and their status relative to the continuum of care**	
3.1	a. Outreach workers bring new clients into care, link clients to needed services and, if required, refer them to case management services. b. The provider will have referral procedures in place for individuals not eligible under Ryan White.	• Documentation in client file • Agency Intake Policy and Procedure
4.0	**Standard #4: Removing barriers to care to support and encourage consumers to remain in care**	
4.1	The provider agency will identify barriers in accessing HIV related medical care and/or evaluation of each client lost to follow-up.	• Barriers identified and documented in client's file.
5.0	**Standard #5: Follow-Up Activities to assist consumer's in receiving the benefits of the EMAs continuum of care and remain in care**	
5.1	a. The provider agency will schedule medical appointments and referrals to appropriate services. b. The provider agency will close out a client's file after 60 days, or after the client has kept two regularly scheduled appointments and is engaged in on-going services.	• Documentation in client's file.

IV. ADMINISTRATIVE REQUIREMENTS:

	STANDARD	MEASURE
1.0	**Standard #1: Outreach worker identification which verifies a workers official relationship to the provider agency**	
1.1	Provider agencies will supply outreach workers with an identification card, badge or other identification that	• Agency Policy and Procedure

	STANDARD	MEASURE
	establishes the workers' official relationship with the provider agency.	
2.0	**Standard #2: Training, and Experience which verifies the staff member's qualifications to provide services**	

	STANDARD	MEASURE
2.1	a. Initial Training - Within the first six (6) months of employment, outreach workers will complete at least ten (10) hours medical, at least ten (10) hours psychosocial and at least eight (8) hours cultural competency training. b. Other Training - Within three (3) months of employment outreach workers will obtain certification in first aid/CPR and non-violent crisis intervention. Outreach workers will maintain first aid/CPR and non-violent crisis intervention certifications as required. c. In addition, All programs and their staff will show evidence: i. That staff is knowledgeable about Ryan White programs and has 1 year of documented HIV/AIDS care and prevention experience. ii. Of knowledge about accessing venues of at-risk populations (family-planning clinics, substance-abuse treatment programs, penal and drug-treatment transition houses, shelters, soup kitchens, bars, social clubs, open air drug markets, etc.). iii. Of knowledge about available resources, access issues and the capacity to direct clients to primary-medical, support and ancillary services.	• Documentation in personnel file.
3.0	**Standard #3: Continuing Education to ensure that staff members are up-to-date in current treatment modalities and support models for those who are HIV+ and HIV affected**	
3.1	After the first year of employment, outreach workers will obtain	• Documentation of all training in personnel file.

	STANDARD	MEASURE
	a minimum of fifteen (15) hours per year of continuing education in HIV/AIDS related topics that may include: • HIV, substance-abuse and drug-treatment services, mental health, domestic violence, clinical trials/protocols/vaccines, tuberculosis, sexually transmitted diseases, partner notification, bereavement, cultural competence, nutrition, housing services, suicide, adolescent health issues, communication, opportunistic infections, commercial sex work, gay/bisexual and transgender concerns, and other related topics.	
4.0	**Standard #4 Staff Supervision**	
4.1	The supervisor must be a licensed MSW with a minimum of three (3) years supervisory experience including one (1) year experience with PLWH/A.	• Review of personnel files indicates compliance. • Agency Policy and Procedure.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard

Service Category: Outpatient/Ambulatory Health Services (Primary Medical Care)

I. <u>DEFINITION OF SERVICE:</u> **Outpatient/Ambulatory Health Services (**Primary Medical Care) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

II. <u>OUTCOMES:</u> Reduce morbidity and mortality of PLWH

III. ADMINISTRATIVE :

	STANDARD	MEASURE
1.0	**Standard #1 - All primary care providers and clinic staff will meet the education and credentialing requirements for providing HIV/AIDS clinical standards of comprehensive care.**	
1.1	Primary Health Care Clinics will be licensed and where applicable accredited to deliver primary medical care.	• There is documentation on site of licensor and/or accreditation for facility.
1.2	a. Facility staff will have current licensor and/or certifications as required by the State of Michigan. b. Physicians must be Infectious Disease Doctors that specialize in HIV	• Personnel files

IV. PRIMARY CARE STANDARDS OF PRACTICE:

<table>
<tr><th colspan="2">STANDARD</th><th>MEASURE</th></tr>
<tr><td>1.0</td><td colspan="2">Standard #1 - All Ryan White Part A funded Primary Care providers will adhere to generally accepted standards of practice as set forth by the USPHS/IDSA guidelines, including the use of Antiretroviral Agents in the treatment of HIV/AIDS infected adults, children, adolescents and pregnant women.</td></tr>
<tr><td>1.</td><td>Core Elements of HIV Primary Care may include:
• Evaluate HIV related complaints
• Establish a strong patient-provider relationship
• Initiate a complete medical database
• Assess patient's understanding of HIV disease
• Identify health needs for current medical problems, including those associated with mental health, substance abuse, hepatitis and hypertension.
• Assess the need for social and psychological intervention
• Assess the need for consultants for medical, social or psychiatric care.
• Describe HIV disease in lay terms, including natural history, laboratory tests (CD4 cell count and viral load), complications, treatment and outcome.
• Complete a history and physical exam.
• Order appropriate lab tests.
• All HIV positive women will have basic GYN exams and the appropriate follow up.
• Patient has been prescribed the appropriate antiretroviral and /or combination therapy.
• Screening for TB status.
• Screening for clinical trials and offered where appropriate.
• Identify high risk behaviors and provide education for HIV prevention of transmission
Prophylaxis and treatment of opportunistic infections</td><td>Documentation will be the client's file.</td></tr>
</table>

V. PRIMARY CARE SERVICE COORDINATION AND DELIVERY:

	STANDARD	MEASURE
1.0	**Standard #1 - Services are a part of the coordinated continuum of HIV/AIDS and specialty care services.**	
1.1	Primary Care services will be integrated into a coordinated continuum of HIV/AIDS and specialty care services available on site or by referral.	• A documented referral system is in place and that patient service plans are appropriate to each circumstance.
1.2	Primary Care providers will inform patients about HIV/AIDS services.	• Health Care Provider has established collaborative relationships with local community based organizations.
2.0	**Standard #2 - Care decisions are made in partnership between provider and patient, or designee, where applicable.**	
2.1	Primary Care service patients are provided information about treatment options.	• Documentation of patient instructions and education regarding treatment options in patient file. • Documentation of interventions to assist patient adherence to a plan of care in patient file.

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Psychosocial Support

I. **DEFINITION:** Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

II. **OUTCOME:** To ensure that minimum standards for the provision of psychosocial services are met. To provide services directed toward identification and remediation of barriers that focus on HIV-related problems.

III. ELIGIBILITY:

	STANDARD	MEASURE
1.0	**Standard #1 - Baseline Evaluation: Address psychosocial needs.**	
1.1	An initial evaluation process should be performed, consisting of two components (intake and assessment). Intake to be consistent with that found in the Universal standards. Assessment should include: • Review of services offered and discussion of client need. • Determination of the appropriate psychosocial support services.	• Agency policy and procedure • Client file

IV. CONTINUED SERVICES

	STANDARD	MEASURE
1.0	**Standard #1 - Follow-up visits should adhere to the following protocols.**	
1.1	The agency will provide: • Evidence of an initial eligibility screening and initial assessment. • Evidence of client progress toward meeting established goals through documentation of activities such as sign-in sheets, case notes, etc. • Evidence of reasonable client to staff ratio. • Evidence that information and referrals are provided to clients. • Evidence of written criteria for services, intake process, discharge, transfer and closing procedures.	• Agency policy and procedure • Client file
1.2	On-going counseling should be monitored on a periodic basis, at least once every quarter, to determine whether the client and/ or the agency's service goals are being met.	• Agency policy and procedure • Client file

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Medical Transportation Services

I. **DEFINITION OF SERVICE:** Medical Transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

II. **OUTCOME:** Maintain / improve medical compliance.

III. **ADMINISTRATIVE:**

	STANDARD	MEASURE
1.0	**Standard #1 - All drivers will be licensed as necessary**	
1.1	**All** - All drivers will have at minimum a valid chauffeur's license.	• A valid copy of the Chauffeur's License will be in each driver's employee file.
1.2	**Direct** – All driving records of drivers will be checked once a year.	• A copy of the current driving record will be in each driver's employee file.
1.3	**Direct –** All vehicles will have appropriate, up-to-date registration and insurance.	• Agency will have current documentation on file
2.0	**Standard #2 - All vehicles will be maintained inclusive of appropriate equipment**	
2.1	**Direct –** All vehicles will have regular maintenance and inspections according to the vehicle maintenance schedule.	• Documentation of vehicle maintenance history will be on file as well as policies and procedures for routine service and inspection will be available

IV. LEVEL OF NEED – MEDICAL TRANSPORTATION:

	STANDARD	MEASURE
1.0	**Standard #1 - Services will be provided based on a client's level of need**	

STANDARD		MEASURE
1.1	All clients will be screened for transportation eligibility using a Level of Need tool and will receive bus, cab, or van services as appropriate.	• The completed Level of Need form will be in all client files
1.2	All HIV+ clients who do not meet the criteria will be appropriately referred.	• Documentation of referrals given for other transportation resources will be on file

V. ACCESSIBILITY:

STANDARD		MEASURE
1.0	**Standard #1 - Transportation services will be accessible to clients with disabilities**	
1.1	Providers are responsible for ensuring that medical transportation services are available to all clients including those who may require assistive devices.	• Presence of handicapped equipment on vehicle in the service provider's fleet. • Evidence that proper maintenance of transport mechanisms are available and documented.
1.2	**Direct –** All handicapped transportation services will provide curb to curb assistance.	Agency policy and procedure and notification to client of limitation of drivers on file.
2.0	**Standard #2 - Transportation services will be accessible to clients with immediate needs and after business hours.**	
2.1	All clients in need of immediate transportation services due to an unexpected appointment will have access to same day services.	• There will be policy and procedure for the provision of same day services.
2.2	Transportation services will be made available for all clients with needs outside of normal business hours.	• There will be policy and procedure for accommodating clients between 5 p.m. and 7 a.m.

VI. SAFETY:

STANDARD		*MEASURE*
1.0	**Standard #1 - All transportation services will be provided to ensure the safety of all passengers and adherence to state vehicle safety laws.**	
1.1	**Direct –** All vehicles will have standard safety equipment in compliance with federal and state laws.	• policy and procedure on driver and passenger safety

Southeastern Michigan HIV/AIDS Council (SEMHAC)
Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard
Service Category: Treatment Adherence

I. **DEFINITION:** Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

II. **OUTCOME:** Improve adherence to complex HIV treatments for PLWH

III. **ELIGIBILITY:**

STANDARD		MEASURE
1.0	**Standard #1 - Baseline Evaluation for determining Eligibility and Component of Services**	
1.1	Clients who have missed scheduled medical appointments over the previous 12 months and/or clients who are not following medical regimens or clients new to medication regimens	• Agency Policy and Procedure • Client file
1.2	The provision of services should assist clients with the following: • Keeping medical appointments • Adhering to medication regimen(s)	• Agency Policy and Procedure
1.3	Services should include the following: • Intake process • Adherence plan that includes: **I.** Description of barriers **II.** Strategies to help overcome the barriers **III.** Other interventions that lead to the goal of becoming fully adherent • Referral, as needed	• Client file

IV. KNOWLEDGE, EXPERIENCE AND CONTINUING EDUCATION:

	STANDARD	MEASURE
1.0	**Standard #1 - Licensing, knowledge, skills and experience of personnel.**	
1.1	Treatment adherence services will be provided by a peer counselor. The peer counselor should have experience working with HIV positive consumers and be able to appropriately model adherent behavior. The peer counselor must have completed high school and training through at least one local or state sponsored HIV training program.	• Agency and Policy and Procedure • Personnel file • Documented training (ongoing)

V. CONTINUED SERVICES:

	STANDARD	MEASURE
1.0	**Standard #1 - Services performed should adhere to the following protocols**	
1.1	The adherence plan, including interventions, must be developed with the client and signed by client.	• Client file
1.2	Review and update of the adherence plan should be performed periodically, at minimum quarterly.	• Client file

VI. PROGRESS REPORTING:

	STANDARD	***MEASURE***
1.0	***Standard #1 - Minimum reporting requirement***	
1.1	At a minimum, adherence progress reporting should be completed periodically as the client progresses through his/her plan and should include the following: • Self reporting, by percentage, the level of compliance with taking medication and keeping medical appointments during a given period of time, at minimum quarterly. • Planned interventions	• Client file • Self reporting tool

VI. FILE CLOSURE FOR TREATMENT ADHERENCE SERVICES:

STANDARD		MEASURE
1.0	**Standard #1 - The agency shall have procedures in place for closing treatment adherence service files.**	
1.1	The closure of treatment adherence service files will be based on the following: • The client's inactivity for six months. • Client moves out of the service area. • Behavior of the client that demonstrates chronic non-adherence or unwillingness to participate in the service despite of efforts by the service provider.	• Agency Policy and Procedure • Client file

Detroit Eligible Metropolitan Area (DEMA)
Ryan White Part A - Care Standard

Service Category: Emergency Financial Assistance

I. DEFINITION: Emergency financial assistance is the provision of short-term payment for essential utilities and for medication assistance when other resources are not available.

II. OUTCOME: Maintain and/or improve medical stability of PLWH

III. ELIGIBILITY:

	STANDARD	MEASURE
1.0	**Standard #1 - Established Service Eligibility Criteria**	
1.1	Agencies have eligibility requirements for financial assistance available upon request	• Agency policy and procedure
1.2	Consumer Eligibility will include: Universal Standards Items Documentation of financial need	• Client records
1.3	Agency determines maximum dollar amounts within a specified timeframe.	• Agency Policy and Procedure
2.0	**Standard #2 - Services are part of the coordinated continuum of HIV/AIDS services**	
2.1	Referrals: • Agency receives referrals from a broad range of sources • Agency will make referrals, where appropriate, to other community resources	• Referrals received and/or provided in the client record and/or CDS

FUNDING SOURCES FORM

Applicant **must** indicate revenue available to support the service category being applied for through this RFP **HIV/AIDS Specific Funding ONLY**

AGENCY:	**SERVICE CATEGORY:**		
Source (specify source)	**Current Funding**	**Period of Award (please note those funding sources which will not continue)**	**Pending Grant Requests**
Local Government			
Neighborhood Opportunity Funds			
State Government (specify Department/Bureau)			
MDCH/Bureau of Substance Abuse Services (HIV/AIDS Early Intervention Program)			
Federal Government			
Ryan White PART BI (funds directly from MDCH, not DHWP)			
Ryan White Title III			
Ryan White Title IV			

AGENCY:	**SERVICE CATEGORY:**		
Source (specify source)	**Current Funding**	**Period of Award (please note those funding sources which will not continue)**	**Pending Grant Requests**
Ryan White Part F: Dental Reimbursement			
Ryan White Part F: SPNS			
HOPWA			
CDC			
SAMHSA			
Other Federal (Please Specify)			
Foundations			
Michigan AIDS Fund			
Other Foundation Funding (Please Specify)			
Other			
Corporation			
Individuals			
Earned Income (fundraisers, events, etc...)			
Membership Income			

DO NOT INCLUDE ANY FUNDS ANTICIPATED THROUGH THIS PROPOSAL
SUMMARY OF FUNDING SOURCES FORM

NAME OF APPLICANT:

	FEDERAL	FEDERAL	SOURCE	SOURCE	CITY / STATE	PRIVATE	TOTAL BUDGET
OBJECT CLASS CATEGORIES							
PERSONNEL							
FRINGE BENEFITS							
TRAVEL							
EQUIPMENT							
SUPPLIES							
CONTRACTUAL							
OTHER							
TOTAL DIRECT CHARGES							
TOTAL INDIRECT CHARGES ***							
TOTAL COSTS							
CONTRACT PERIOD - BEGIN DATE:							
CONTRACT PERIOD - END DATE:							

1. Combine amounts for all contracts.
2. Include a legend that identifies the contract period for each funding source.
3. **** Indirect Charges - allowable only with a federally approved indirect cost rate.**

PROGRAM BUDGET SUMMARY

DHWP				Page 1 of 4	
Program **RYAN WHITE – PART A**	**Service Category**	**Code**		**Budget Period** 3/1/10 – 2/28/11	**Date Prepared**
Local Agency:		Original Budget X	Amended Budget ___	Amendment Number ___	EIN
Address:		Telephone ( )			

	CATEGORY	AGREEMENT BALANCE				
		DIRECT SERVICE	**ADMIN**	**TOTAL**		
1	Salaries & Wages					
2	Fringe Benefits					
3	Travel					
4	Supplies & Materials					
5	Contractual (Sub-Contracts)					
6	Equipment					
7	Other Expenses:					
8						
9	Indirect Costs					
10	TOTAL DIRECT					
11	TOTAL EXPENDITURES					
12	Less: Fees & Collections					
13	FUNDS REQUIRED					
14	State Agreement ___ %					
15	Local ______ %					
16	Federal					
17	TOTAL FUNDING					

CERTIFICATION: I certify that I am authorized to sign on behalf of the local *Agency*. This budget represents costs necessary for the administration and operation of the program. Adequate documentation and records will be maintained to support all required program expenditures.

NAME: TITLE: DATE:

PROGRAM BUDGET - POSITION SCHEDULE

Program **RYAN WHITE – PART A**			**Code**	**Budget Period** 3/1/10 – 2/28/11	**Date Prepared**
Agency					
POSITION DESCRIPTION	**POSITIONS REQUIRED**	**X ANNUAL SALARY**	**# of MONTHS**	**= TOTAL SALARY**	**COMMENTS**
TOTAL	FTE			$	

PROGRAM BUDGET - COST DETAIL SCHEDULE

Program **RYAN WHITE – PART A**	**Code**	**Budget Period** 3/1/10 – 2/28/11
Agency:		

DESCRIPTION	**ITEM TOTAL**		**TOTAL**
	Direct Service	Admin	
FRINGE BENEFITS			
FICA			
Workmen's Compensation			
MESC			
TOTAL FRINGE BENEFITS			
TRAVEL			
Mileage			
Parking			
TOTAL TRAVEL			
SUPPLIES AND MATERIALS			
Office Supplies			
TOTAL SUPPLIES AND MATERIALS			
CONTRACTUAL			
TOTAL CONTRACTUAL			

EQUIPMENT			
TOTAL EQUIPMENT			

PROGRAM BUDGET - COST DETAIL SCHEDULE

Program **RYAN WHITE – PART A**	**Code**	**Budget Period** 3/1/10 – 2/28/11
Agency:		

DESCRIPTION	**ITEM TOTAL**		**TOTAL**
	Direct Service	**Admin**	
OTHER EXPENSES			
Office Space			
Communication			
Printing/Duplication			
Liability Insurance			
Equipment Maintenance			
TOTAL OTHER EXPENSES			
Sub-Total Cost Detail			
Salary from Position Schedule			
Indirect costs (calculated @ x%)			
TOTAL BUDGET REQUEST			$

BUDGET NARRATIVE & JUSTIFICATION				
SALARY				
Job Title	**Job duties and responsibilities as they relate to the funded program**	**Annual Salary**	**% of time to be paid for by this grant**	**Amount charged to the grant**
TOTAL FOR FRINGE BENEFITS				$
SUPPLIES & MATERIALS				
Item	**Reason for Purchase**			**Cost**
Office supplies				
TRAVEL	**Travel Where And By Whom**			**Cost**

BUDGET NARRATIVE & JUSTIFICATION		
CONTRACTUAL (Subcontracts)		$
Item	**Reason**	**Cost**
EQUIPMENT		$
Item	**Reason**	**Cost**
OTHER EXPENSES		**$**
Item	**Reason for purchase**	**Cost**
INDIRECT COSTS	*Calculated at what rate*	