Boston Public Health Commission
AIDS Program
1010 Massachusetts Avenue
Boston, MA 02118

MA Department of Public Health
HIV/AIDS Bureau
250 Washington Street
Boston, MA 02108

Standards of Care for HIV/AIDS Services

2004

For Adoption/Foster Care, Client Advocacy, Complementary/ Holistic Therapies, Day Care, Drop-In Center, Emergency Assistance, Food, Mental Health, Peer Support, Respite Care, Substance Abuse, Transportation, and Volunteer Support Services

Written and produced by

Boston AIDS Consortium

142 Berkeley Street
Boston, MA 02116
www.bacboston.org

A community working together is essential to winning the fight against HIV/AIDS.

This project is supported by funding provided by the Boston Public Health Commission through Title I of the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act of 1990, as amended in 1996 and 2000, and by the Massachusetts Department of Public Health HIV/AIDS Bureau.

Standards of Care for HIV/AIDS Services

2004

For Adoption/Foster Care, Client Advocacy, Complementary/ Holistic Therapies, Day Care, Drop-In Center, Emergency Assistance, Food, Mental Health, Peer Support, Respite Care, Substance Abuse, Transportation, and Volunteer Support Services

Written and Produced by
Jeremy Holman

Boston AIDS Consortium

142 Berkeley Street
Boston, MA 02116
www.bacboston.org

A community working together is essential to winning the fight against HIV/AIDS.

Additional copies of this document can be downloaded at
www.bphc.org/aids or www.mass.gov/dph/aids

Table of Contents

Introduction

The following standards of care were developed by the Boston Public Health Commission (BPHC) and the Massachusetts Department of Public Health (MDPH) for HIV/AIDS services funded through each agency. The process to develop and publish these standards was coordinated by the Boston AIDS Consortium, under contract with the MDPH and BPHC, and included a working group of individuals representing the BPHC, MDPH, the Boston EMA Title I HIV Health Services Planning Council, and the MA Association of Title II HIV Care Consortia. The goal of the process was to consolidate existing standards of care into a single set that would apply to all providers funded for services through Ryan White CARE Act Title I, Title II, and MA state funds.

The development of the standards also included the input and feedback of service providers and consumers throughout MA and the Boston Eligible Metropolitan Area (EMA). Draft standards were distributed throughout MA and the Boston EMA in early May 2003 with a two week public comment period. All comments were thoroughly reviewed by the working group resulting in some recommended revisions. The final document was reviewed and approved by the BPHC and MDPH.

Part I of the Standards of Care apply to all funded programs and are known as **Universal Standards of Care**. Each section begins with the objectives of the specific group of standards, and is followed by specific standards and measures. The standards of care in Part I apply to all programs funded by the MDPH and the BPHC for any of the services listed below.

- Adoption/Foster Care
- Client Advocacy
- Complementary Therapies
- Day Care (Adult and Pediatric)
- Drop-In Center
- Emergency Assistance
- Food
- Mental Health
- Peer Support
- Respite Care
- Substance Abuse
- Transportation
- Volunteer Support

In addition to these universal standards, **Part II** contains additional standards that apply to each specific service category. These standards apply to specific components of service delivery and vary for each category. Providers of these services must comply with the Universal Standards in Part I, as well as the service specific standards in Part II.

The BPHC and MDPH would like to thank those individuals and agencies that contributed their time, energy, and expertise to help complete these standards. Specifically, BPHC and MDPH would like to acknowledge the following individuals who participated in the Standards of Care Workgroup:

- Alicia Turoff, Boston Public Health Commission
- Michael Goldrosen, Boston Public Health Commission
- Hutson Inniss, Massachusetts Association of Title II HIV Care Consortia
- Charlot Lucien, MA Department of Public Health
- Alison Mehlman, MA Department of Public Health
- Lee Swislow, Boston EMA Title I HIV Health Services Planning Council

Part I: Universal Service Standards

Part I: Universal Service Standards

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by Ryan White Title I (through Boston Public Health Commission) or Ryan White Title II and/or MA state funds (through MA Department of Public Health). The standards of care establish the **minimum standards** intended to help agencies meet the needs of their clients. **Providers may exceed these standards**.

The objectives of the universal service standards are to help achieve the goals of each service type by ensuring that programs:

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

1.0 Agency Policies and Procedures

The objectives of the standards for agency policies and procedures are to:

- ensure that policies and procedures are in place that protect clients' rights, guarantee confidentiality, and ensure quality care;
- ensure a fair process to address clients' grievances;
- clarify clients' rights and responsibilities to help facilitate communication and service delivery; and
- ensure that agencies comply with appropriate state and federal regulations.

These standards of care are based on respecting the inherent dignity of each client. Emphasis is placed on encouraging client autonomy and independence in daily living. All provider agencies offering services must have written policies that address client confidentiality, release of information, client rights and responsibilities, universal precautions, eligibility, and client grievance procedures.

Confidentiality assures protection of release of information regarding HIV status, behavioral risk factors, or use of services. Each agency will have a client confidentiality policy that is in accordance with state and federal laws. As part of the confidentiality policy, all agencies will provide a **Release of Information Form** describing under what circumstances client information can be released (name of agency/individual with whom information will be shared, information to be shared, duration of the release consent, and client signature). Clients shall be informed that permission for release of information can be rescinded at any time either verbally or in writing. Releases must be dated, including an expiration date. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), the release of information form must be a HIPAA-compliant disclosure authorization.

Programs must also have a **consent form** in which clients grant permission for BPHC or MDPH to review client files on site during site visits. For clients who choose not to sign the client consent form, agencies must be able to code all unique identifying information in accordance with all federal, state, and local laws.

A provider agency **grievance procedure** ensures that clients have recourse if they feel they are being treated in an unfair manner or do not feel they are receiving quality services. Each agency will have a policy identifying the steps a client should follow to file a grievance and how the grievance will be handled. The final step of the grievance policy will include information on how the client may appeal the decision if the client's grievance is not settled to his/her satisfaction within the provider agency.

1.0 Agency Policies and Procedures

Standard		Measure	
1.1	Client confidentiality policy exists.	1.1	Written policy on file at provider agency.
1.2	Grievance policy exists.	1.2	Written policy on file at provider agency and posted in a visible location.
1.3	Agency has eligibility requirements for services, in written form, available upon request.	1.3	Written policy on file at provider agency.
1.4	Procedure for obtaining client consent exists.	1.4	Client consent form on file and documented procedure to code identifying information in files for clients who refuse consent.
1.5	All client records are stored in a secure and confidential location.	1.5	Records stored in a locked file or cabinet with access limited to appropriate personnel.
1.6	Agency has written policies and documentation to address the following issues: • Physical plant safety • Medical/Health care • Infection control and transmission risk management (e.g., needle sticks) • Crisis management • Personnel • Risk assessment and response • Service planning • Documentation • Client/Guardian rights and responsibilities • Client Progress Review • Client Discharge and Transition Process	1.6	Written policies on file at provider agency.

2.0 Program Safety

The objectives of establishing minimum standards for program safety are to ensure that:

- services are provided in settings that meet local, state, and federal regulations that guarantee the well-being of clients and staff on site, off site, or during operations pertaining to the services (i.e., transportation);
- facilities are clean, comfortable, and free from hazards; and
- facilities are accessible to clients, including children (when appropriate) and/or people with disabilities.

2.0 Program Safety	
Standard	**Measure**
2.1 Program promotes and practices Universal Precautions.	2.1 Written policy on file at provider agency.
2.2 Program is ADA compliant for site/physical accessibility. In the case of programs with multiple sites offering identical services, at least one of the sites must be in compliance with the relevant ADA requirements.	2.2 Signed confirmation on file.
2.3 Program has a policy for health and safety related incidents that is available in the agency and has been reviewed with all staff.	2.3 Written policy on file at provider agency.
2.4 Agency complies with all required state and federal safety regulations, including OSHA.	2.4 Signed confirmation, whenever necessary, on file.

3.0 Personnel

The objectives of the standards of care for personnel are to ensure that:

- clients have access to the highest quality of care through qualified staff;
- supervisors are clear about their job responsibilities; and
- staff and supervisors receive training and supervision to enable them to perform their jobs well.

All staff and supervisors will be given and will sign a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. At a minimum, all staff should be able to provide appropriate care to clients infected/affected by HIV/AIDS, be able complete all documentation required by their position, and have previous experience (or a plan for acquiring experience) in the appropriate service/treatment modality (for clinical staff). **See the attached service specific standards for additional competencies for some service categories.** Clinical staff must be licensed or registered as required. Administrative/program staff will have previous experience in human services or appropriate education or training. A bachelor's degree may substitute for experience in the case of individuals providing administrative or non-clinical support.

Staff and program supervisors will receive consistent administrative supervision (minimum of 1 hour per month) and for clinical staff, clinical supervision (minimum of 1 hour per month). Administrative supervision addresses issues related to staffing, policy, client documentation, reimbursement, scheduling, training, quality enhancement activities, and the overall operation of the program and/or agency. Clinical supervision addresses any issue directly related to client care and job related stress (e.g., boundaries, crisis, burnout). It is recommended that staff in need of clinical supervision have two separate supervisors for clinical and administrative supervision. If clinical and administrative are not provided separately, staff should have the option to seek clinical supervision externally and/or separate from their administrative supervisor.

3.0 Personnel			
	Standard		**Measure**
3.1	Staff have the minimum qualifications expected and other experience related to the position.	3.1	Resume in personnel file.
3.2	Staff and supervisors will know the requirements of their job description and the service elements of the program.	3.2	Written job description provided to and signed by staff and kept in personnel file.
3.3	Newly hired staff will be oriented within 6 weeks, and will begin initial training within 3 months of being hired. On-going training should continue throughout staff's tenure.	3.3	Documentation in personnel file of (a) completed orientation within 6 weeks of date of hire; (b) commencement of initial training within 3 months of date of hire; and (c) on-going completed trainings.
3.4	Staff will receive at least one hour of administrative supervision per month, and when required, one hour of clinical supervision per month.	3.4	Signed statement on file between each staff member and supervisor regarding the frequency of supervision.

4.0 Cultural and Linguistic Competence

The objective for establishing standards of care for cultural and linguistic competence is to ensure that clients receive services that are culturally and linguistically appropriate.

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

Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among individuals that enables effective delivery of services to people living with HIV. **Linguistic competence** is the ability to communicate effectively with people living with HIV, including those whose preferred language is not the same as the provider's, those who are illiterate or have low literacy skills, and/or those with disabilities. It is important to remember that cultural and linguistic competence is a goal toward which all providers must aspire, but one that may never be completely achieved given the diversity of languages and cultures throughout our communities. However, all providers should be involved in a continual process of learning, personal growth, experience, education, and training that increases cultural and linguistic competence and enhances the ability to provide culturally and linguistically appropriate services to all individuals living with HIV/AIDS. **Culturally and linguistically appropriate services** are services that:

- respect, relate, and respond to a client's culture, in a non-judgmental, respectful, and supportive manner;
- are affirming and humane, and rely on staffing patterns that match the needs and reflect the culture and language of the communities being served;
- recognize the power differential that exists between the provider and the client and seek to create a more equal field of interaction; and
- consider each client as an individual, and do not make assumptions based on perceived or actual membership in any group or class.

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

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

On-going trainings that help build cultural and linguistic competence may include traditional cultural and linguistic competency trainings, as well as a range of trainings that help build specific skills and knowledge to work and communicate more effectively with the communities we serve.

4.0 Cultural and Linguistic Competence

Standard		Measure	
4.1	Programs shall recruit, retain, and promote a diverse staff that reflects the cultural and linguistic diversity of the community.	4.1	Programs will have a strategy on file to recruit, retain and promote qualified, diverse, and linguistically and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of people living with HIV/AIDS.
4.2	All staff shall receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.	4.2	All staff members attend appropriate training at least one (1) time per year. Maintain copies of training verification in personnel file.
4.3	Programs shall understand the cultural and linguistics needs, resources, and assets of its service area and target population(s).	4.3	Programs will collect and use accurate demographic, epidemiological, and service utilization data in service planning for target population(s). Verified through Grantee site visit. Data maintained in a place that is easily accessible for review.
4.4	Programs' physical environment and facilities are welcoming and comfortable for the populations served.	4.4	Grantee site visit.
4.5	All programs must ensure access to services for clients with limited English skills.	4.5	Programs shall ensure access to services in one or more of the following ways (listed in order of preference): • Bilingual staff who can communicate directly with clients in preferred language; • Face-to face interpretation[1] provided by qualified staff or contract or volunteer interpreters; • Telephone interpreter services (for emergency needs or for infrequently encountered languages); or • Referral to programs with bilingual/bicultural clinical, administrative and support staff and/or interpretation services by a qualified bilingual/bicultural interpreter.

Continued on next page →

[1] **Interpretation** refers to verbal communication that translates speech from a speaker to a receiver in a language that the receiver can understand. **Translation** refers to the conversion of written material from one language to another.

4.0 Cultural and Linguistic Competence (continued)	
4.6 Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent in the client's language. Family member or friend must be over the age of 18.	4.6 Family/friend interpretation consent form signed by client and maintained in client record.
4.7 Interpreters and bilingual staff, volunteers, and contracted providers must demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting and knowledge in both languages of the terms relevant to the services to be provided.	4.7 Resume and documentation of training in file; For interpreters, copy of certification on file at agency.
4.8 Clients shall be informed of their right to obtain no-cost interpreter services in their preferred language.	4.8 Rights and responsibilities policy contains notice of the right to obtain no-cost interpreter services (see Standard 1.0).
4.9 Clients shall have access to linguistically appropriate signage and educational materials.	4.9 Programs must provide commonly used educational materials and other required documents (e.g., grievance procedures, release of information, rights and responsibilities, consent forms, etc) in the threshold language[2] of all threshold populations.[2] Programs that do not have threshold populations[2] must have a documented plan for explaining appropriate documents and conveying information to those with limited English proficiency.

Continued on next page →

[2] A **threshold population** is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program and Haitian-Creole would be considered a **threshold language**. Some programs may target multiple groups, and therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

4.0 Cultural and Linguistic Competence (continued)	
4.10 Programs shall conduct on-going assessments of the program and staff's cultural and linguistic competence.	4.10 Programs will integrate cultural competence measures into program and staff assessments (e.g., internal audits, performance improvement programs, patient satisfaction surveys, personnel evaluations, and/or outcome evaluations).

5.0 Intake and Eligibility

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

- inform the client of the services available and what the client can expect if s/he were to enroll;
- establish the client's eligibility for services, including HIV status and other criteria;
- establish whether the client wishes to enroll in a range of services or is interested only in a discrete service offered by the provider agency;
- collect required state/federal client data for reporting purposes;
- collect basic client information to facilitate client identification and client follow up; and
- begin to establish a trusting client relationship.

All clients who request or are referred to HIV services will participate in the intake process. Intake is conducted by an appropriately trained program staff or intake worker. The intake worker will: review client rights and responsibilities; explain the program and services to the client; explain the agency's confidentiality and grievance policies to the client; assess client needs; secure permission from client to release information (if there is an immediate need to release information); and begin to complete the client intake form. The intake form must include the Joint HIV/AIDS Client Information Form (required by BPHC and MDPH) and any other service specific information that pertains to the program.

A client who chooses to enroll in services and who is eligible will be assigned a staff member who is responsible for making contact with the client to set up a time for a more thorough assessment, if necessary, to determine appropriate services. Referrals for other appropriate services will be made if ineligible. The intake process will begin within five (5) days of the first client contact with the agency. Ideally, the client intake process should be completed as quickly as possible; however, recognizing that clients may need additional time to feel comfortable revealing sensitive information, and/or may not have on hand the required documentation (e.g., documentation of HIV status), the intake process should be completed within 30 days of beginning intake.

5.0 Intake and Eligibility

Standard	Measure
5.1 Intake process is completed within 30 days of initial contact with client.	5.1 Uniform intake tool completed within 30 days of beginning intake with completed tool in client's record.
5.2 Eligibility for provider services is determined if client chooses to enroll.	5.2 Physician's note or laboratory test in client's record.
5.3 Client's wishes for release of information is determined, if there is an immediate need to release information.	5.3 A dated and signed release of information form in client's record. Releases are considered no longer binding if more than one year old.
5.4 Client's consent for on-site file review by funders is determined.	5.4 Signed and dated consent form in client's record. In event of refusal of consent, file must be coded to remove identifying information in accordance with federal, state, and local laws.
5.5 Client is informed of rights and responsibilities, confidentiality, and grievance policies.	5.5 Intake tool indicates that client has been informed of confidentiality policy and grievance policy. Policy documentation has been signed or initialed by client, a copy is in client record, and a copy has been given to the client.

6.0 Assessment and Service Plan

The objectives of the standards for assessment and service plan are to:

- gather information to determine the client's needs;
- develop and strengthen provider-client relationship;
- identify the client's goals and develop action steps to meet them;
- identify a timeline and responsible parties for meeting the client's goals; and
- ensure coordination of care with appropriate collateral providers and referral to needed services.

Assessment

A comprehensive assessment and service plan is the responsibility of the client's case manager (see Case Management Standards of Care) and primary care provider, in collaboration with the client. However, all service providers must assess the client's needs for the provider service(s) to develop an appropriate service plan.

Service assessments should include an assessment of all issues that may affect the need for the provider service, such as:

- medical history and health status;
- available financial resources (including insurance);
- availability of food, shelter, transportation, and financial resources;
- available support system (family, friends, others); and/or
- need for legal assistance.

This information may be available from the case manager and primary care physician, contingent upon the client's signed release of information on file with those parties. In the event this information is not available, it should be collected as part of the provider agency's assessment.

The assessment should be a cooperative and interactive endeavor between the staff and the client. The client will be the primary source of information. However, with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information, if the client grants permission to access these sources. The assessment should be conducted face-to-face within 30 days of intake, with accommodations for clients who are too sick to attend the appointment at the provider agency.

The assessment process is fluid. As the client's status changes, his/her needs may change. It is the responsibility of the staff to reassess the client's needs with the client. The assessment should be reviewed as needed, as determined by the staff, but no less than once every six (6) months. The staff member is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's well being. Staff members must comply with established agency confidentiality policies (see Standard 1.0) when engaging in information and coordination activities.

Service Plan

The purpose of the service plan is to guide the provider in delivering high quality care at a level corresponding to the client's need. The plan should be developed collaboratively between the

staff and the client. It should include goals, based upon the needs identified in the assessment, and actions steps needed to address each goal (short and long term). The plan should include specific services needed and referrals to be made, including clear time frames and an agreed upon plan for follow up.

As with the assessment process, service planning is an on-going process. It is the responsibility of the staff to review and revise a client's service plan. Service plans should be revised as needed, as determined by the staff, but not less than once every six (6) months.

At a minimum, the service plan should include:

- a description of the specific services needed;
- goals and objectives to address needs; and
- resources/services to meet each need, including time frames and responsible party.

As part of the service plan, programs must ensure the coordination of services. Coordination of services requires identification of other staff or service providers with whom the client may be working. As appropriate and with client consent, program staff will act as a liaison among clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision. If a program is unable to provide a specific service, it must be able to make immediate and effective referrals. In case of referrals, staff must facilitate the scheduling of appointments, transportation, and the transfer of related information.

6.0 Assessment and Service Plan	
Standard	**Measure**
6.1 Conduct client assessment within 30 days of intake.	6.1 Completed assessment form in the client record that documents: • medical history and health status; • available financial resources (including insurance); • availability of food, shelter, transportation, and financial resources; • available support system (family, friends, others); and/or • need for legal assistance.

Continued on the next page →

6.0 Assessment and Service Plan (continued)	
Standard	**Measure**
6.2 Develop service plan collaboratively with the client within 30 days of intake.	6.2 Completed service plan in client record signed by the client and supervisor that includes: • a description of the specific services needed; • goals and objectives to address the needs; and • resources/services to meet each need, including time frames and responsible party.
6.3 Conduct reassessment of client needs, as needed, but not less than once every six months.	6.3 Documentation of reassessment in the client records (e.g., progress notes, update notes on the initial assessment, or new assessment form).
6.4 Review service plan and revise, as needed, but not less than once every six months.	6.4 Documentation of service plan review/revision in client's record (e.g., progress notes, update notes on initial service plan, or new service plan).
6.5 Program staff will identify and communicate as appropriate (with documented consent of client) with collateral service providers to support coordination and delivery of high quality care.	6.5 Documentation in client record of other staff with whom the client may be working.

7.0 Transition and Discharge

The objectives of the standards for transition and discharge are to:

- ensure a smooth transition for a client who no longer wants or needs services at the provider agency;
- track accurately only clients receiving active services;
- assist provider agencies in more easily monitoring caseload; and
- plan after-care and re-entry into service.

A client may be discharged from any service through a systematic process that includes a discharge summary in the client's record. The discharge summary will include a reason for the discharge and a transition plan to other services or other provider agencies, if applicable. Agencies should maintain a list of available resources available for the client for referral purposes. If the client does not agree with the reason for discharge, (s)he should be informed again of the provider agency's grievance procedure. A client may be discharged from any service for the following reasons:

- at the request of the client;
- if a client's needs change and (s)he would be better served through services at another provider agency;
- if a client's actions put the agency, staff, or other clients at risk and/or if there are documented and repeated violations by the client of the client rights and responsibilities;
- if a client moves out of the service area (if possible, an attempt should be made to connect client to services in the new service area);
- client's death; or
- if after repeated and documented attempts, an agency is unable to reach a client for a period of 12 months.

7.0 Transition and Discharge	
Standard	**Measure**
7.1 Agency will have a Transition and Discharge procedure in place that is implemented for clients leaving or discharged from services.	7.1 Completed Transition/Discharge Summary form on file, signed by client (if possible) and supervisor. Summary Form should include: • reason for discharge; and • a plan for transition to other services, if applicable, with confirmation of communication between referring and referral agencies, or between client and agency, up to 6 months after discharge date.
7.2 Agency will have a process for tracking active and inactive clients.	7.2 Documentation of agency process for tracking active and inactive clients.
7.3 Agency will provide clients with referral information to other services, as appropriate.	7.3 Resource directories, or other material on HIV related services, on file and provided to clients.

8.0 Accessibility of Services

The objectives of the standards for accessibility of services are to ensure that services are accessible for people living with HIV/AIDS. Providers must have the willingness and capacity to make services accessible to a wide range of individuals living with HIV/AIDS, including linguistic and cultural minorities and individuals with disabilities.

8.0 Accessibility of Services	
Standard	**Measure**
8.1 Agency complies with ADA criteria for programmatic accessibility.	8.1 Completed City or State/Title II form on file.
8.2 Services are available in settings accessible to low income individuals.	8.2 Grantee site visit with review of, but not limited to, hours of operation, location, proximity to transportation, and other accessibility factors.
8.3 Services are available to any individual who meets program eligibility requirements, within funded capacity.	8.3 Written eligibility requirements on file; grievance policy on file; client utilization data made available to Grantee.
8.4 Program demonstrates willingness to provide services to all affected communities reflected in the organization's funding proposal.	8.4 Agency mission statement on record. Client service utilization data indicate use by populations in proposal.
8.5 Programs include input from consumers (and as appropriate, care givers) in the design and evaluation of service delivery.	8.5 Documentation of meetings of consumer advisory board, or other mechanisms for involving consumers in service planning and evaluation (e.g., satisfaction surveys, needs assessments) in regular quarterly or annual reports to funder(s).

Part II: Service Specific Standards

Part II: Service Specific Standards

In addition to the Universal Standards of Care, providers of services must also meet additional standards that are specific to certain services. This section contains standards of care specific to the following services:

- Adoption/Foster Care
- Client Advocacy
- Complementary Therapies
- Day Care
- Drop-In Center
- Emergency Assistance
- Food
- Mental Health
- Peer Support
- Respite Care
- Substance Abuse
- Transportation
- Volunteer Support

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

Adoption/Foster Care

Adoption/Foster Care Service Definition

Services funded under this category include, but are not limited to: temporary (foster) care, permanent (adoption) homes, early planning, permanency planning, and other legal services that assist children under the age of 20 whose parents or guardians are unable to care for them because of HIV-related illness or death.

Adoption/Foster Care Standards of Care

The service specific standards of care for **Adoption/Foster Care** provide additional requirements on the following components of service provision:

A. Agency Licensing and Policies
B. Competencies

Adoption/Foster Care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objectives of the standards for agency licensing and policies for **Adoption/Foster Care** services are to ensure that programs engaged in child placement services:

- have clearly delineated policies regarding child protection, parental access, and custody-related and/or legal issues;
- demonstrate compliance with MA or NH state regulations, including licensing requirements for Child Placement Agencies (as applicable); and
- follow all state and federal guidelines for licensing prospective parents.

A. Agency Licensing and Policies		Adoption/Foster Care	
Standard		**Measure**	
A.1	Agency is licensed and accredited by the appropriate local/state/federal agency.	A.1	Current license on file at provider agency.
A.2	Agency has policies to address: ▪ Child protection ▪ Parental access ▪ Custody or other legal issues	A.2	Written policies on file at provider agency.
A.3	Agency follows state and federal guidelines for licensing prospective parents (as applicable).	A.3	Guidelines for licensing and documented procedure on file at provider agency; must include a written policy clearly delineating family characteristics necessary for foster care or adoption.

B. Competencies

The objectives of the competencies standards for **Adoption/Foster Care** services are to ensure that:

- program staff are qualified to provide services such as: counseling, permanency planning, mental/emotional evaluations, outreach programs, needs assessments, prospective household assessments, medical health evaluations, legal representation, and/or advocacy for clients and program staff. If not, programs must have the capacity to provide effective and immediate referrals; and
- staff comply with all state and federal licensing guidelines (e.g., renewal and training).

At a minimum, all program staff hired to administer adoption/foster care programs will have the ability to coordinate physical/mental health care for children infected/affected by HIV/AIDS, the ability to complete documentation as required by their positions, and have the necessary qualifications and/or previous experience in the human service delivery field.

B. Competencies	Adoption/Foster Care
Standard	**Measure**
B.1 Staff will have the skills, experience, registration, and licensing qualifications appropriate to providing adoption/foster care services.	B.1 Resume and/or current license on file.
B.2 Agency will provide legal advocacy, representation, protection, and clarification of issues related to custody and guardianship for all clients and program staff. If not, agency must have capacity to refer.	B.2 Legal qualifications of staff are documented and kept on file; contact list with relevant resources on file at provider agency.

Client Advocacy

Client Advocacy Service Definition

Services funded under this category provide assistance to clients in accessing and obtaining services that include, but are not limited to: financial, legal, ombudsperson, and other relevant needs experienced by the client that may be met by non-licensed, paraprofessionals trained in accessing such services through an established referral network.

There are no service specific standards of care for **Client Advocacy** services. Please refer to the Universal Standards for the required standards for this service.

Complementary/Holistic Therapies

Complementary/Holistic Therapies Service Definition

Services funded under this category include, but are not limited to: acupuncture; chiropractic treatment; massage therapy; and other holistic modalities. The purpose of this category is to provide services that enhance adherence to care, such as symptom management.

Complementary/Holistic Therapies Standards of Care

The overall objectives of the Complementary/Holistic Therapies standards of care are to ensure that:

- all clients enrolled in complementary/holistic therapy services have been referred by their primary health care provider as required by federal regulations (or substance abuse counselor in the case of referrals for acupuncture associated with substance abuse treatment); and
- programs provide the highest quality of care available.

The service specific standards of care for **Complementary/Holistic Therapies** provide additional requirements on the following components of service provision:

A. Intake

For programs that offer **acupuncture services**, providers must also comply with additional standards of care on the following components of service provision:

B. Agency Licensing and Policies
C. Competencies

Acupuncture is a therapeutic treatment provided by a licensed acupuncturist that involves the use of sterile, disposable acupuncture needles inserted in clients for the purpose of assisting them with their healthcare management.

A. Intake

The objective of the intake standards for **Complementary/Holistic Therapies** is to ensure that clients have been referred to services by a primary care physician, as required by federal regulations from the Health Resources Services Administration (HRSA).

A. Intake	Complementary/Holistic Therapies
Standard	**Measure**
A.1 Clients who use complementary therapies have been referred by a primary care physician, as required by federal regulations.	A.1 Documentation of referral from primary care physician in client's record.

NOTE: The standards on the next 2 pages only apply to acupuncture services provided as part of the Complementary/Holistic Therapies service category.

B. Agency Licensing and Policies

The objective of the agency licensing and policies standards for **Complementary/Holistic Therapies** is to ensure that **acupuncture services** protect the health and well-being of clients and staff.

The standards below apply only to acupuncture services provided under this service category.

B. Agency Licensing and Policies	Complementary Therapies (Acupuncture)
Standard	**Measure**
B.1 Clinical staff providing acupuncture services must have appropriate professional liability coverage.	B.1 Documentation of malpractice insurance (in good standing) on file at provider agency.
B.2 Clinical staff providing acupuncture services must test negative for TB or be in a non-communicable stage of treatment.	B.2 TB testing required prior to employment and annually thereafter; test results documented in personnel files.
B.3 Clinical staff providing acupuncture services shall be vaccinated against Hepatitis B.	B.3 Vaccination for Hepatitis B completed prior to hire, with documentation in personnel file. Staff who refuse vaccination must sign a waiver of such, documented in personnel file.
B.4 Agency shall comply with standards for materials purchase, storage, use, count, and disposal.	B.4 All acupuncture needles must be sterile and prepackaged, used once, and disposed of according to biohazard standards. Agencies must have a documented procedure in place to ensure needle count on insertion and removal.

C. Competencies

The objective of the competencies standards for **Complementary Therapies** is to ensure that **acupuncture services** are provided by licensed and qualified practitioners.

The standards below apply only to acupuncture services provided under this service category.

C. Competencies	Complementary Therapies (Acupuncture)
Standard	**Measure**
C.1 Clinical staff providing acupuncture services must be licensed through the MA Board of Medicine or NH Dept. of Health and Human Services, Board of Acupuncture Licensing.	C.1 Current license on file at provider agency.
C.2 Clinical staff providing acupuncture services shall be certified in CPR.	C.2 CPR training certification in personnel file, with documentation of annual updates.

Day Care Including Pediatric and Adult Day Care (DC)

Day Care Service Definition

Services funded under this category are those designed to provide day care for children with HIV, the siblings of children with HIV, children of a parent or caregiver with HIV, and adults with HIV.

The Day Care category does not include childcare/babysitting services. For this type of service, please see Respite Care.

Though the day care service category definition is the same for adults and children, the needs of these populations may differ. As a result, separate standards have been developed for **pediatric** and **adult day care** services.

Adult Day Care Standards of Care

There are no additional standard of care for **Adult Day Care** programs beyond the Universal Standards in Part I of this document.

Pediatric Day Care Standards of Care

The objectives for the **pediatric day care** service standards are to ensure that programs:

- enhance parental capacity to advocate for the child's needs;
- provide services to children and families in a manner that promotes parental choice and supports the family autonomy; and
- enhance the family's ability to cope with multiple stresses related to caring for children infected/affected by HIV/AIDS.

The service specific standards of care for **Pediatric Day Care** provide additional requirements around the following components of service provision:

A. Agency Licensing and Policies
B. Competencies
C. Assessment and Service Plan
D. Accessibility

Pediatric day care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objectives of the standards for agency licensing and policies for **Pediatric Day Care** services are to ensure that programs comply with MA or NH state regulations and licensing requirements for pediatric day care services.

A. Agency Licensing and Policies	Pediatric Day Care
Standard	**Measure**
A.1 In Massachusetts, pediatric day care programs must be licensed by the MA office of Child Care Services (MA OCCS) and adhere to all MA day care licensing regulations (102 CMR 7.00) and other MA regulations that apply to pediatric day care facilities. In New Hampshire, day care providers must be licensed with NH Bureau of Child Care Licensing (NH BCCL) and adhere to all NH day care licensing regulations (He-C 4002.01) and other NH regulations that apply to pediatric day care facilities.	A.1 Current license on file at provider agency.
A.2 Programs must identify any policies or procedures that vary from MA or NH state regulations, note why the variance is necessary to support optimal client care, and document approval of the variance by the appropriate state licensing board (MA OCCS or NH BCCL).	A.2 Documentation on file at provider agency of the request for and approval of variance by the relevant state day care licensing office.

B. Competencies

The objectives of the competencies standards for **Pediatric Day Care** services are to ensure that day care programs:

- have the capacity to provide the level of medical management necessary to maintain the health and safety of children infected/affected with HIV/AIDS enrolled at the facility; and
- can address the special needs of children infected/affected by HIV/AIDS, including but not limited to, provisions for modifications to curriculum and activities, quiet/resting space, special feeding techniques, special nutrition and dietary requirements, learning, emotional, and behavioral needs, neurological impairments, developmental disabilities, medications, adaptive devices, and aggressive behavior.

B. Competencies	Pediatric Day Care
Standard	**Measure**
B.1 The **Director** of a center that includes children infected/affected by HIV/AIDS shall have the following qualifications, in addition to the qualifications described in the MA OCCS or the NH BCCL regulations: • valid certificate in pediatric first aid, including rescue breathing and first aid for choking; • valid certification in infant and child cardiopulmonary resuscitation; and • knowledge of community resources that are available to children with special needs and the ability to utilize these resources for the purpose of making referrals or achieving interagency coordination.	B.1 Resume on file in personnel records. Copies of valid certifications in pediatric first aid and infant and child CPR on file in personnel records.
B.2 Facilities providing services to children with special needs shall have one licensed/certified teacher who is certified in special education. Compliance is met if one caregiver is certified in special education.	B.2 Resume on file.

Continued on next page →

B. Competencies (continued)	Pediatric Day Care
B.3 If special nutritional requirements and feeding procedures are necessary to support the care of children with HIV disease, a center shall have access to nutritional consultation or support staff. Consultant or support staff may include food service staff, a Child Care Nutrition Specialist, or a registered nurse with training and/or experience in dietary and feeding requirements of children infected/affected by HIV/AIDS.	B.3 Resume (for employed staff) or documentation of linkage to and use of consultation staff on file.
B.4 If children living with HIV who require medical management are included in the facility, a registered nurse shall be employed on a full-time or part-time basis to provide staff training and on-going supervision of staff and to administer medication to children as appropriate.	B.4 Resume on file.
B.5 Staff or consultants shall include professionals knowledgeable in the field of developmental disabilities, including but not limited to, a physician, registered dietitian, registered nurse or pediatric nurse practitioner, psychologist, physical therapist, occupational therapist, speech pathologist, social worker, and/or a parent of a child living with HIV/AIDS.	B.5 Resume (for employed staff) or documentation of use of consultants on file.
B.6 Each center shall designate a licensed physician, registered nurse, nurse practitioner or physician's assistant with pediatric or family health training and experience with the care of children living with HIV/AIDS as the program's **Health Care Consultant**.	B.6 Resume on file of the health consultant.
B.7 Staff members caring for children are trained and knowledgeable on childcare, child development, HIV/AIDS, and the affected community.	B.7 Resumes and/or documentation of completed training(s) on file.
B.8 All drivers, passenger monitors, and assistants involved in the transportation of medically involved children or children with special needs shall be certified in infant/child CPR.	B.8 Valid certification of infant/child CPR on file in personnel records for drivers, passenger monitors, and transportation assistants.

C. Assessment and Service Plan

The objectives of the standards for assessment and service plan for **Pediatric Day Care** services is to ensure that programs:

- involve parents in the assessment, service planning, and decision making for the care of their child;
- enhance parental capacity to advocate for their child's needs; and
- respond effectively to the changing needs of the child and family.

C. Assessment and Service Plan	Pediatric Day Care
Standard	**Measure**
C.1 Parents shall participate in the assessment, service planning, and decision-making, including all aspects of the child's developmental and educational program.	C.1 Client assessment, service plan, and reevaluation reports are signed by parent/guardian and are kept in client records. Daily notes in client records.
C.2 Information about the child's daily needs and activities shall be shared with parents on a daily, informal basis.	C.2 Daily notes in client records.
C.3 Program shall provide skill-building and child guidance opportunities for parents to enhance their capacity to advocate for the child's needs.	C.3 Program plan on file. Documentation of parent involvement is documented in client log or records.
C.4 Needs and service plan shall be reassessed every 6 months to respond to the changing needs of the family and child. Acute changes in health status or behavior shall warrant immediate reassessment by appropriate staff and client's parent/guardian.	C.4 Documentation of 6-month review and reassessment in client's chart, signed by parent/guardian, including documentation of any changes in health or behavior.

D. Accessibility

The objectives of the accessibility standards of care for **Pediatric Day Care** services are to ensure that programs that provide special therapies are accessible to and appropriate for children.

D. Accessibility	Pediatric Day Care
Standard	**Measure**
D.1 If the facility provides special therapies on site, there shall be separate rooms or private areas for physical therapy, occupational therapy, and speech therapy.	D.1 Designated separate rooms or private areas in facility for special therapies. Grantee site visit.

Drop-In Center

Drop-In Center Service Definition

Drop-In Center services offer individuals with HIV/AIDS a setting where they can access peer support, social, recreational, and educational activities and overcome stigma and isolation.

A client may need assistance overcoming stigma and isolation, and dealing with difficult socio-economic or psycho-social conditions that are a result of his/her HIV status. A drop in center offers a space for clients to address these issues, gather information about services available in the community, build skills and activities of daily living and socialize with other individuals facing similar issues. These activities are coordinated by either a Drop-In Center coordinator or Case Manager depending on the region/location where services are provided.

Drop-In Center service activities must emphasize education, health promotion, prevention, and risk reduction, and facilitate access to health care. Services may include a range of educational, recreational, and social activities that meet these goals.

Drop-In Center Service Standards of Care

The overall objectives of the drop-in center service standards of care are to ensure that programs establish a range of appropriate activities (e.g., support groups, socialization, educational) that support the goals of education, health promotion, and risk reduction and facilitate access to health care.

The service specific standards of care for **Drop-In Center services** provide additional requirements on the following components of service provision:

A. Program
B. Intake

Drop-In Center providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Program

The objective of the program standards for **Drop-In Center** is to ensure that programs offer a range of activities that promote the prevention goals of the funder and facilitate access to care and health promotion.

A. Program		Drop-In Center	
Standard		**Measure**	
A.1	Agency offers a range of educational and recreational activities, 2-3 of which must be regular/recurrent activities that focus on health promotion, prevention, and risk reduction.	A.1	Document on file at provider agency that details the range of activities offered, defines core service areas, and lists the activities that pertain to each service area.
A.2	Activities will promote or facilitate access to health care and referral to other needed services.	A.2	Documentation of referral activities.

B. Intake

The objectives of the standards for intake for Drop-In Center is to ensure that clients

- are matched with appropriate resources and activities; and
- are linked to a continuum of care through case management and a primary care provider.

B. Intake		Drop-In Center	
Standard		**Measure**	
B.1	Intake process will include a process of matching the client's needs with available activities and resources.	B.1	Signed document (list) indicating clients preferences for activities.
B.2	Drop-In Center clients will be assessed at intake for linkages to case management and primary care.	B.2	Intake tool must include assessment and documentation of case manager and primary care provider

Emergency Assistance

Emergency Assistance Service Definition

Emergency assistance services consist of short-term financial assistance to help people living with HIV/AIDS meet emergency needs when all other options have been exhausted. Emergency assistance services are limited to assistance with transportation, food, housing (including essential utilities), and medication. **Emergency assistance may not be provided to clients in cash.**

Emergency Assistance Standards of Care

The overall objectives of the emergency assistance standards of care are to ensure that

- services are provided to clients who are eligible and in greatest need;
- programs have exhausted all other options for meeting clients' needs; and
- clients are enrolled in the continuum of care.

The service specific standards of care for **Emergency Assistance** provide additional requirements on the following components of service provision:

A. Agency Policies

Emergency assistance providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Policies

A. Agency Policies — Emergency Assistance			
Standard		**Measure**	
A.1	Eligibility is restricted by income and budget management activities are offered.	A.1	Proof of monthly income on file, and documentation of offer of budget management assistance.
A.2	Client is enrolled in services.	A.2	Documentation of verification of enrollment in other HIV/AIDS services.
A.3	Agency has written protocol for distribution of funds, including documentation.	A.3	Written protocol on file at provider agency.

Food Services

Food Services Service Definition

The service funded under this category is the provision of calorically and nutritionally appropriate prepared food, which may include, but is not limited to: prepared meals; congregate meals; home delivered food; food banks; nutritional supplements; and the provision of nutritional counseling under the supervision of a registered dietician.

Food Services Standards of Care

The overall objectives of the food services standards of care are to ensure that programs:

- assess and respond appropriately to the physical, nutritional, dietary, and therapeutic needs of clients; and
- prepare meals in adherence to Food and Drug Administration (FDA) food preparation standards for people living with HIV.

The service specific standards of care for **Food Services** provide additional requirements on the following components of service provision:

A. Agency Licensing and Policies
B. Competencies

Food services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objectives of the standards for agency licensing and policies for **Food Services** are to ensure that programs:

- demonstrate compliance with MA or NH state sanitation standards and registration/licensing regulations; and
- provide services to clients in need.

A. Agency Licensing and Policies	Food Services
Standard	**Measure**
A.1 Agency complies with local, state, and federal sanitation and safety regulations.	A.1 Food and safety inspections by state agency and/or Grantee.
A.2 Eligibility requirements should include criteria for those who are unable or less able to purchase foods and/or prepare their own nutritionally adequate meals. Supplements should be provided to those who are unable to eat solid food or require additional nutrition.	A.2 Written eligibility policy on file at provider agency.

B. Competencies

The objectives of the competencies standards for **Food Services** are to ensure that:

- clients have access to the highest quality services through experienced and trained staff; and
- staff comply with all state and federal licensing guidelines.

At a minimum, all program staff hired to provide or administer food services will be able to provide appropriate care to clients infected/affected by HIV/AIDS, complete documentation as required by their positions, and, for clinical staff, prior experience in the appropriate treatment modality. Clinical staff must possess the appropriate licensure if applicable.

Administrative/program staff will have previous experience in human services, food service provision, ideally in a health care setting, and/or appropriate education/training. A bachelor's degree may substitute for experience in the case of individuals providing administrative or non-clinical support.

B. Competencies	Food Services
Standard	**Measure**
B.1 Staff will have the skills, experience, registration, and licensing qualifications appropriate to providing food services.	B.1 Resume and/or current license on file.
B.2 Program staff must be able to handle food safely (i.e., identify sanitation procedures for the purchase, receipt, storing, issue, preparation, and service of safe food and beverage products as required by state and/or local regulations).	B.2 Procedures on file. Maintain records on certain foods (e.g., perishable foods, labeling of food and chemical containers, etc.)

Mental Health

Mental Health Service Definition

Services funded under this category are psychological and psychiatric treatment, counseling and case consultation services provided by professional therapists (licensed or authorized within the state).

Mental Health Standards of Care

The overall objectives of the mental health standards of care are to ensure that programs:

- have policies in place to protect clients' rights;
- provide services with licensed professionals who have appropriate education and experience; and
- assess and respond appropriately to the routine and emergency psychosocial, cognitive, and emotional needs of clients with a range of psychosocial issues.

The service specific standards of care for **Mental Health** provide additional requirements on the following components of service provision:

A. Competencies

Mental Health providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objectives of the competencies standards for **Mental Health** services are to ensure that clients have access to the highest quality services through experienced and trained staff.

A. Competencies	Mental Health
Standard	**Measure**
A.1 Staff members are licensed, as necessary, to provide mental health services.	A.1 Current license on file.
A.2 Staff have education and experience in mental health, social work, psychology, addiction/substance use, or psychiatry and are able to respond to the routine and emergency psychosocial, cognitive, and emotional needs of clients.	A.2 Resume on file.

Peer Support

Peer Support Service Definition

Services funded under this category provide assistance to clients where the person(s) providing the service is a person infected with HIV and of the client's self-identified community. Such services include the provision of culturally competent psychosocial support and assistance in obtaining a range of services and entitlement that will meet the needs of the client and are provided by nonlicensed, para-professional individuals. The purpose of this category is to provide services to a full spectrum of individuals infected by HIV.

Peer Support Standards of Care

The overall objectives of the Peer Support services standards of care are to ensure that programs:

- provide opportunities for sharing information and resources, with the goal of promoting self-advocacy by people living with HIV/AIDS; and
- facilitate the development of social and emotional support networks by and for people living with HIV/AIDS.

The service specific standards of care for **Peer Support** services provide additional requirements around the following components of service provision:

A. Competencies

Peer support providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objectives of the competencies standards for **Peer Support** services are to ensure that:

- clients have access to the highest quality services through experienced and trained staff; and
- support group facilitators are able to provide culturally and linguistically appropriate services.

A. Competencies	Peer Support
Standard	**Measure**
A.1 Peer support staff will have the skills and experience appropriate to the relevant peer support treatment modality, including the ability to coordinate information and referrals for clients and assist in group facilitation.	A.1 Resume on file.
A.2 Peer-facilitated peer support services are provided by people who are HIV positive.	A.2 Peer-facilitated support services staff self-identify as people living with HIV/AIDS.
A.3 For peer support services that are provided by a professional who is not a person living with HIV/AIDS, the staff person must be licensed.	A.3 Resume and current license on file.
A.4 Peer support clinical supervisors will have at least the minimum qualifications expected from mental health or social workers.	A.4 Resume on file.
A.5 Peer support group facilitators are culturally and linguistically appropriate for the support group and target population.	A.5 Support group facilitators are representative of the population served and/or have the demonstrated skills, experience, and training necessary to provide services to the target population; resume and relevant training documented in personnel file.

Respite Care

Respite Care Service Definition

Services funded under this category are residential and/or home-based non-medical assistance programs designed to relieve the primary caregiver(s) responsible for providing day-to-day care. This care encompasses that of an adult or children as clients with HIV, or HIV negative parents or caregivers of HIV positive children.

Respite Care Standards of Care

The overall objectives of the Respite Care standards of care are to ensure that programs:

- are provided by individuals cognizant of the respite needs of individuals living with HIV/AIDS or by individuals designated by the client as a member of his or her natural support network; and
- respond to the routine and emergency respite needs of clients.

The service specific standards of care for **Respite Care** services provide additional requirements around the following components of service provision:

A. Competencies

Respite Care providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Competencies

The objective of the competencies standards for **Respite Care** services is to ensure that clients have access to the highest quality services through experienced and trained staff or by individuals from the client's network.

A. Competencies	Respite Care
Standard	**Measure**
A.1 Staff will have the skills, experience, and qualifications appropriate to providing respite care services. When the client designates a community respite care giver who is a member of his or her natural network, this designation suffices as the qualification.	A.1 Resume on file.
A.2 If a respite care giver is from the client's network, the client shall sign a disclaimer acknowledging that the care giver may not always meet all of the requirements expected of the agency's paid staff.	A.2 Disclaimer, signed by the client, and filed in client's record, including the name(s) of the respite care giver(s).
A.3 A respite care giver from the client's network shall receive basic orientation or training on the provision of emergency and routine respite care services.	A.3 Documentation of orientation or training on file.

Substance Abuse Services

Substance Abuse Services Category Definition

Services funded under this category may include: pretreatment program of recovery readiness; harm reduction; mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; drug-free treatment and counseling; neuro-psychiatric pharmaceuticals; and relapse prevention in an outpatient or residential health service setting.

Substance Abuse Services Standards of Care

The overall objectives of the substance abuse standards of care are to ensure that programs:

- comply with MA or NH state regulations, including licensing requirements, for substance abuse services; and
- are staffed by skilled, licensed professionals with experience and/or education in relevant disciplines.

The service specific standards of care for **Substance Abuse** services provide additional requirements around the following components of service provision:

A. Agency Licensing and Policies
B. Competencies

Substance Abuse Services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

The objectives of the standards for agency licensing and policies for **Substance Abuse Services** are to ensure that programs comply with MA or NH state regulations and licensing requirements.

If residential substance abuse treatment services are provided in a facility that primarily provides inpatient medical or psychiatric care, the component providing the substance abuse treatment must be separately licensed for that purpose. CARE Act funds may not be used for inpatient detoxification in a hospital setting.

A. Agency Licensing and Policies	Substance Abuse Services
Standard	**Measure**
A.1 Agency is licensed and accredited by appropriate state agency to provide substance abuse services.	A.1 Current license(s) on file.

B. Competencies

The objective of the competencies standards for **Substance Abuse Services** is to ensure that: clients have access to the highest quality services through experienced and trained staff.

B. Competencies	Substance Abuse Services
Standard	**Measure**
B.1 Staff members are licensed or certified, as necessary, to provide substance abuse services and have experience and skills appropriate to the specified substance abuse treatment modality.	B.1 Current license and resume on file.

Transportation

Transportation Service Definition
Services funded under this category include, but are not limited to taxi vouchers and public and private transport services that enable clients and their caregivers to access HIV related healthcare and psychosocial services.

Transportation Standards of Care
The objectives of the standards of care for transportation services are to ensure that:

- transportation approved for reimbursement is accessible to eligible individuals living with HIV/AIDS and their care givers;
- clients have access to the highest quality of services through trained and experienced staff;
- transportation services are safe, timely, and reliable and facilitate access to medical and psychosocial services; and
- programs are soundly coordinated and administered by qualified persons with designated administrative and program responsibilities.

The service specific standards of care for **Transportation** services provide additional requirements around the following components of service provision:

A. Agency Licensing and Policies
B. Program Safety

Transportation services providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Agency Licensing and Policies

A. Agency Licensing and Policies	Transportation
Standard	**Measure**
A.1 Transportation programs serving children must be a Medicaid provider or must use a Medicaid eligible transport service.	A.1 Documentation of Medicaid status.

B. Program Safety

The objective of the program safety standards for **Transportation** service is to ensure the safety of clients, including those with mobility impairments or other disabilities.

B. Program Safety	Transportation
Standard	**Measure**
B.1 Program has the capacity to provide transportation that is accessible to individuals with disabilities, as required by the ADA.	B.1 Grantee site visit and/or contract monitoring process.
B.2 Volunteer ride programs are provided by trained volunteers who possess valid driver's licenses, liability insurance, and safe driving records.	B.2 Documentation on file, including copies of driver's license, liability insurance coverage, and driving record.
B.3 Volunteer drivers receive training on the agency's policies and protocols for health and safety related incidents.	B.3 Emergency protocol for health and safety related incidents is reviewed with all staff at least once per year and is posted in the agency.
B.4 Vehicles that are part of van or volunteer ride programs shall contain first aid kits.	B.4 First aid kits in van or volunteer ride vehicles. Grantee site visit or contract monitoring process.
B.5 Volunteer and private transportation is provided in registered and insured vehicles.	B.5 Copies of registrations and insurance coverage on file.
B.6 Volunteers who transport clients understand their responsibilities and obligations in the event of an accident, including the extent of their liability.	B.6 Signed and dated form on file that outlines responsibilities, obligations, and liabilities.
B.7 Operators of volunteer and private transportation agree to follow the established agency policy in the event of an accident.	B.7 Program has a written accident policy on file; policy reviewed and signed by volunteer and private transportation operators and kept on file.

Volunteer Support

Volunteer Support Service Definition

Volunteer Support includes a wide range of services provided by volunteers that promote individual companionship and psychosocial support for clients and their families. This category includes practical support such as transportation, housekeeping, medical appointments, food delivery, and any other activity requested by the client that does not cause any liability to the agency.

Volunteer Support, as defined in this section, refers to services directly provided to HIV positive individuals and their families, and does not include administrative work performed for an organization.

At any given time, a client may need assistance meeting his/her practical support needs. In order to meet the wide variety of needs, an agency should have an internal system to match the particular skills of volunteers to the requested activity of the client.

Volunteer Support Standards of Care

The objectives of the standards of care for volunteer support are to ensure that:

- programs establish a range of appropriate activities that can be offered by volunteers;
- services enhance the quality of life of clients; and
- volunteers deliver high quality services.

The service specific standards of care for **Volunteer Support** services provide additional requirements around the following components of service provision:

A. Program
B. Personnel

Volunteer Support service providers are expected to comply with the Universal Standards of Care, as well as these additional standards.

A. Program

The objective of the program standards for **Volunteer Support** services is to ensure that programs have established a range of appropriate activities that can be offered through volunteers that enhance the quality of life of clients and promote access to care.

A. Program	Volunteer Support
Standard	**Measure**
A.1 Agencies will maintain a list of volunteer support activities or opportunities that are available at the site.	A.1 List on file at provider agency.
A.2 Volunteer support activities promote access to care and enhance quality of life.	A.2 Documentation of service utilization by clients served through volunteer support services (e.g., chart review, annual assessment, or other activities).

B. Personnel

The objective of the personnel standards for **Volunteer Support** services is to ensure that volunteers deliver high quality services.

B. Personnel	Volunteer Support
Standard	**Measure**
B.1 Volunteers will be oriented and trained before working with clients. Orientation must include issues of confidentiality, client rights and responsibilities, and boundaries.	B.1 Documentation of completed orientation and training on file at provider agency signed by volunteer and supervisor.
B.2 Volunteers will be offered supervision at least once per month, and as needed.	B.2 Documentation of supervision sessions by supervisors on file at provider agency.
B.3 Agency has protocols or policies to support volunteer recruitment, recognition, and retention.	B.3 Protocols or policies on file at provider agency.