DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

HIV/AIDS, Hepatitis, STD and TB Administration

Food Bank/Home Delivered Meals

The purpose of these service standards is to outline the elements and expectations all Ryan White service providers are to follow when implementing a specific service category. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists in the Washington, DC Eligible Metropolitan Area (EMA) such that customers of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

I. SERVICE CATEGORY DEFINITION

The goal of Food Bank/Home-delivered Meals (FB/HDM) is to provide nutritionally appropriate meals or groceries to HIV+ individuals who are nutritionally compromised in order to improve health outcomes and support the ability of these consumers to remain in their homes and in medical care.

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

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

Program Guidance:

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

II. INTAKE AND ELIGIBILITY

The Ryan White HIV/AIDS Program has the following eligibility criteria: residency, financial, and medical. HRSA requires Ryan White customers to maintain proof of eligibility annually. Supporting documentation is required to demonstrate customer eligibility for Ryan White Services.

A. INITIAL ELIGIBILITY DETERMINATION

1. **HIV-positive status:** written documentation from a medical provider or laboratory reports denoting viral load.

2. **Residency:** The following are acceptable methods of meeting the burden for residency:

    - Current lease or mortgage statement
    - Deed settlement agreement

- Current driver's license
- Current voter registration card
- Current notice of decision from Medicaid
- Fuel/utility bill (past 90 days)
- Property tax bill or statement (past 60 days)
- Rent receipt (past 90 days)
- Pay stubs or bank statement with the name and address of the customer (past 30 days)
- Letter from another government agency addressed to customer
- Active (unexpired) homeowner's or renter's insurance policy
- DC Healthcare Alliance Proof of DC Residency form
- If homeless, a written statement from case manager, facility or letter from landlord that customer is a resident

3. **Income:** Customer income may not exceed 500% of the Federal Poverty Level (FPL). Income sources should be reported by the customer and any household members for whom customers have legal responsibility. For each income source, the customer must indicate the gross amount, how often the income is received, and whether it is your income or a household member's from each source.

   The following are acceptable forms of proof of income:

   - Pay stubs for the past 30 days. The pay stub must show the year to date earnings, hours worked, all deductions, and the dates covered by the paystub
   - A letter from the employer showing gross pay for the past 30 days, along with a copy of the most recent income tax return
   - Business records for 3 months prior to application, indicating type of business, gross income, net income, and most recent year's individual income tax return. A statement from the customer projecting current annual income must be included
   - Copy of the tenant's lease showing customer as the landlord and a copy of their most recent income tax return
   - SSD/SSI award letters, unemployment checks, social security checks, pension checks, etc. from the past 30 days
   - Zero income attestation form and/or a letter from a supporting friend or family member stating how they support the customer

B. INTAKE

To establish a care relationship, the customer intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of person completing intake
3. Customer name, address and phone number
4. Referral source, if appropriate
5. Language(s) spoken and/or preferred language of communication
6. Literacy level (customer self-report)
7. Emergency contact information
8. Communication method to be used for follow-up
9. Demographics (sex at birth/current gender/date of birth/race/ethnic origin)
10. Veteran status
11. Any other data required for the CareWare system
12. Any other service-specific data
13. Documented explanation about the services available within the provider agency and within the Ryan White Program

C. MAINTENANCE OF ELIGIBILITY

To maintain eligibility for Ryan White services, providers must conduct annual eligibility confirmations to assess if the customer's income and/or residency status has changed. RWHAP providers are permitted to accept a customer's self-attestation of "no change" when confirming eligibility, however, self-attestation could be used every other annual confirmation and not be used in two consecutive years.

ACCESS TO HOME DELIVERED MEALS ONLY

Home Delivered Meals provides meals, groceries and nutrition counseling to people living with life-challenging illnesses. Determination of eligibility is entirely health-based. All meals are free-of-charge to the customer. Customers must be referred by a healthcare provider to enroll in the program.

To be eligible for services, one must have the qualifying Ryan White requirements (HIV status, proof of residency and proof of income) and must have a comorbidity, compromised nutritional status, and/or a limited ability to prepare his/her own meals due to a qualifying illness. Qualifying illness include: HIV/AIDS, cancer, poorly-controlled diabetes, stage 5 renal disease, congestive heart failure (NYHA class III or IV), chronic obstructive pulmonary disorder "COPD" (stage III or IV), multiple sclerosis (RRPS, SPMS, PPMS), ALS (middle or late stages), and Parkinson's (Stage III, IV or V).

NUTRITIONAL SCREENING	
Standard	**Measure**
All consumers must be screened to determine their level of nutritional risk and supportive needs. The nutritional screening is not a substitute for the intake process but may be conducted at the same time. • Dietitian/Nutritionist, if available, and the approximate date of the consumer's most recent nutrition assessment • Client's body mass index (BMI) • Client's nutritional concerns • Dietary restrictions • Ability to complete Activities of Daily Living • Any HIV-related illnesses diagnosed in the last six months • Any chronic illness with date of diagnosis • Family members and caregivers (relationship to consumer/gender/date of birth/race/ethnic origin/primary language) and if they need HDM service as well • Current nutrition issues (ex. lack of appetite, nausea/vomiting, involuntary weight loss, diarrhea, inability to prepare or procure food due to health issues, etc.) • Medications and/or Treatments/Therapies **NOTE: Nutrition Assessments and Re-assessments are required for:** • All consumers receiving home delivered meals, HIV-positive children, adolescents and pregnant women, and those found to be at nutritional risk through the screening process. • Assessments are to be completed within two weeks of enrollment into the program and reassessments conducted approximately every six months thereafter.	Documentation of the following information should be recorded in the customer file for the nutritional screening: • Dietitian/Nutritionist, if available, and the approximate date of the consumer's most recent nutrition assessment • Client's body mass index (BMI) • Client's nutritional concerns • Dietary restrictions • Ability to complete Activities of Daily Living • Any HIV-related illnesses diagnosed in the last six months • Any chronic illness with date of diagnosis • Family members and caregivers (relationship to consumer/gender/date of birth/race/ethnic origin/primary language) and if they need HDM service as well • Current nutrition issues (ex. lack of appetite, nausea/vomiting, involuntary weight loss, diarrhea, inability to prepare or procure food due to health issues, etc.) • Medications and/or Treatments/Therapies

• These are the minimum requirements; reassessments may be conducted more frequently if needed. • The agency must determine if a consumer is eligible for home-delivered meals before a registered dietitian/nutritionist is assigned to perform the nutrition assessment. *Programs that offer congregate meals, grocery/pantry bags, and vouchers must provide assessments for those consumers identified to be at nutritional risk through the screening process. It is preferred that assessments are conducted in person, but they may also be done virtually.*	
HOME DELIVERED MEALS ONLY: INDIVIDUALIZED MEAL PLAN (IMP)	
Standard	**Measure**
The IMP is only completed if the consumer is receiving Home Delivered Meals. The Individualized Meal Plan (IMP) should document the medically and nutritionally appropriate diet type for the consumer. It should be reviewed and modified as part of the nutritional re-assessment, or sooner if the medical provider and/or registered dietitian/nutritionist recommends. The IMP should include: 1. Client signature and date, signifying participation with development and agreement with IMP 2. Identification of appropriate medically tailored meal plan based on dietary restrictions and co-occurring illnesses 3. Client signature and date on Client Agreement acknowledging program requirements and participation	• Documentation of IMP in customer's record. The customer's and/or legal guardian's signature and date in the development process and agreement with the IMP on file
COORDINATION & MONITORING	
The needs and status of each consumer receiving Food Bank/Home-Delivered Meals will be monitored. There must be at least one documented contact with active consumers every 60 days or as dictated by consumer need/plan. 1. Case notes documenting each contact with or on behalf of the consumer to implement and continue FB/HDM service 2. Communication with referring agency if service is stopped for any reason 3. Referral to licensed/registered dietician/nutritionist if a nutritional need is identified 4. Documentation of follow-up to missed deliveries in accordance with provider policy	• Documentation in the customer record should include: 1. Customer progress toward objectives of the IMP 2. Documentation of adjustment to the IMP, as necessary 3. Referrals and linkages to programs and services 4. Attendance and follow-up for medical and supportive service appointments 5. Documentation of emergency situations as they arise, such as crisis intervention

Clients can request changed to their service at any time. The provider must work with consumers and dieticians/nutritionists to make sure the most appropriate services are provided.	
HOME DELIVERED MEALS ONLY: PROCEDURE FOR MISSED DELIVERIES	
• Consumers will receive contact information to address engagement and service issues. These calls must be returned within two (2) business days. • Consumers will receive detailed information about their delivery schedules, delivery options, and the provider's missed delivery policy. • For each missed delivery, consumers will receive a voicemail or written message of the time delivery was attempted with instructions for follow-up. • Multiple missed deliveries will result in time-limited suspension of services. In the event of a suspension, staff will outreach to consumers by phone or mail with the date deliveries will resume and instructions for follow-up. Staff will also re-educate consumers on delivery schedule and policy, including alternate delivery options to accommodate consumers' schedules. • When notification is received that a consumer is in the hospital, service will be suspended and the consumer is contacted to resume service once the consumer is discharged from hospital. • All efforts will be made to accommodate consumers' individual dietary needs and preferences. • All efforts will be made to accommodate consumers' availability to receive deliveries.	• Documentation of procedures in file
TRANSITION & DISCHARGE/CASE CLOSURE	
Standard	**Measure**
Case Transfer • If the consumer is being transitioned, the provider must facilitate the transfer of consumer records/information, when necessary. • The consumer must sign a consent to release of information form to transfer records which is specific and dated. **Case Closure/Discharge**	Documentation of discharge plan and summary in customer's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable. Documentation: Customer's record must include: • Date services began • Special customer needs • Services needed/actions taken, if applicable
• Reasonable efforts must be made to retain the consumer in services by phone, letter and/or any communication method agreed upon by the consumer. These efforts must be documented in the consumer's record. • The provider will make appropriate referrals and provide contacts for follow-up. • The provider must document date and reasons for closure of case including but not limited to: • Attainment of goal(s)/service provided as planned • Change in status resulting in program ineligibility	• Date of discharge • Reason(s) for discharge Referrals made at time of discharge, if applicable

• Client termination request • No contact • Client moves out of service area • Client died • A summary of the services received by the consumer must be prepared for the consumer's record.	•

III. PERSONNEL QUALIFICATIONS

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must 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.

1. **Chefs**: involved in food production and menu design must have a high school diploma or GED and be professionally trained/certified with a current food protection and handling license/certification in accordance with the jurisdiction in which they are working in. Chefs must be familiar with the multi-cultural and dietetic needs of the population.
    - Experience in food preparation and cooking for bulk-meal services preferred
2. **Dieticians/Nutritionists**: involved in meal planning and menu design must be registered and licensed, as required by the Jurisdiction
3. **Food Service Workers/Volunteers:** must be professionally trained/certified with a current food protection and handling license/certification.
4. **Food Delivery Drivers:** must have a valid driver's license, familiarity with the geographic region being served and possess good interpersonal communication and writing skills.
5. **Intake and Recertification Coordinators:** should have a Bachelor's Degree in a health or human service related field and a minimum of 1 year experience working with persons with HIV preferred.
6. Providers will provide new hires with training regarding confidentiality, consumer rights and agency's grievance procedure.

IV. CLINICAL QUALITY MANAGEMENT

Include at least one performance measure in the Clinical Quality Management Program for the service. Please refer to Policy Clarification Notice (PCN) #15-02 (updated 09/01/2020).

V. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on August 1, 2023. The next annual review is July 31, 2024.

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