Rehabilitation Services Standard

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 minimally 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, to be used as grant/contract guidance, are essential in defining program expectations and ensuring consistency in quality management.

Sub-recipient Organizations must adhere to all federal, state and local legislative and programmatic requirements and expectations and shall abide by any professional best practices of the service category/health care industry. Guidance shall be issued as updates are officially developed.

I. SERVICE CATEGORY DEFINITION

Rehabilitation Services provide HIV-related therapies to improve or maintain a customer's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care. Rehabilitation services provided as part of inpatient hospital services, nursing homes, and other long-term care facilities are not allowable.

Services: Funds may be used for physical and occupational therapy, speech pathology services, and vocational therapy.

Physical therapy helps to maximize customer's capabilities. Typical programs may include:

- Therapeutic exercise
- Strength and mobility training
- Gait and balance training
- Muscle re-education
- Innovative treatment modalities such as heat, cold, and electrical stimulation

By concentrating on daily living activities, skilled occupational therapists help customers adjust to everyday environments. Therapies may include:

- Education and training in daily living skills, including eating, bathing, dressing, and grooming
- Sensory-motor skills re-training
- Strength and range of motion training
- Cognitive integration techniques
- Selection and use of adaptive equipment
- Design, fabrication, and application of orthoses (splints)
- Speech and language pathology therapies maintain the ability to communicate.
- Therapies may include:
    - Exercises to stimulate receptive, integrative, and expressive processes

- Sensory-motor activities to stimulate chewing, swallowing, articulatory, and voice processes
- Selection and training in the use of no-oral communications aids, including augmentative systems
- Specialized swallowing therapy
- Cognitive skills training

Low vision training teaches the customer how to use their remaining vision more effectively. Services may include rehabilitation training for:

- Reading
- Writing
- Shopping
- Cooking
- Lighting
- Glare control

II. INTAKE, ELIGIBILITY, & ANNUAL RECERTIFICATION REQUIREMENTS

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 applicant (past 30 days)
   - Letter from another government agency addressed to applicant
   - 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 a 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 applicant and any household members for whom applicants have legal responsibility. For each income source the applicant must indicate the gross amount, how often the income is received, and whether it is your income or a household members 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 applicant 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 applicant

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.

III. KEY SERVICE COMPONENTS & ACTIVITIES

Standard	Measure
Comprehensive Assessment: Provider will complete a comprehensive assessment within five (5) business days of the referral to include: • Presenting issue • Physical examination and evaluation performed by the therapist relevant to the type of therapy prescribed • Diagnosis	Documentation of assessment in customer's record signed and dated by licensed professional Documented evidence in the customer's primary record of a completed comprehensive assessment within five (5) business days of referral.
Plan of Care: In collaboration with the customer a plan of care will be developed within ten (10) business days of the completed comprehensive assessment. The plan of care should be signed and dated by the customer and located in the customer's primary record. A copy of the plan will be offered to the customer and documented in the customer's record. The plan of care should include: • Objective for rehabilitative services • Estimated number of sessions • Type of therapy • Estimated duration.	Documentation of plan of care signed and dated by the customer Documented evidence in the customer's primary record of a plan of care developed within ten (10) business days of the completed comprehensive assessment. Documented evidence in the customer's primary record of the plan of care reviewed not less than every six (6) months for progress met toward objective

Documentation that the plan of care is being followed will include date therapy received, therapy performed, and progress toward meeting objectives in the customer's primary record. Plan of care must be reviewed not less than every six (6) months to determine if progress is being met towards meeting objectives with documentation in the customer's primary record.	
Referrals: If the needs of the Customer are beyond the scope of the services provided by the agency/provider, an appropriate referral to another level of care is made. Documentation of referral and outcome of the referral is present in the customer's primary record.	Documented evidence in the customer's primary record of referrals, as applicable, for services necessary. documented evidence of the outcome of the referral made as indicated in the customer's primary record
TRANSITION & DISCHARGE	
Standard	**Measure**
Customer discharged when Rehab Care services are no longer needed, goals have been met, upon death or due to safety issues. Prior to discharge: Reasons for discharge and options for other service provision should be discussed with customer. Whenever possible, discussion should be occurring face-to-face. If not possible, provider should attempt to talk with customer via phone. If verbal contact is not possible, a certified letter must be sent to customer's last known address. If customer is not present to sign for the letter, it must be returned to the provider. Transfer: If customer transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If customer moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If customer cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates	Documentation of discharge 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 ● Date of discharge ● Reason(s) for discharge ● Referrals made at time of discharge, if applicable

(by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the customer's last known mailing address within five business days after the last attempt to notify the customer. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If customer reports that services are no longer needed or decides to no longer participate in the Service Plan, customer may withdraw from services. Because customers may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the customer's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency customers should be referred to appropriate agencies. Administrative Discharge: Customers who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a customer for this reason, the case must be reviewed by the leadership according to that agency's policies. Customers who are discharged for administrative reasons must be provided written notification of and reason for the discharge and must be notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the customer's last known mailing address within five business days after the date of discharge, and a copy must be filed in the customer's chart.	
CASE CLOSURE	
Standard	**Measure**
Case will be closed if customer: ● Has met the service goals ● Decides to transfer to another agency	Documentation of case closure in customer's record with clear rationale for closure

● Needs are more appropriately addressed in other programs ● Moves out of the EMA ● Fails to provide updated documentation of eligibility status thus, no longer eligible for services ● Can no longer be located ● Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan ● Exhibits pattern of abuse as defined by agency's policy ● Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program ● Is deceased	

IV. PERSONNEL QUALIFICATIONS

Competencies, Knowledge and Skills

- If provided by an agency who provides professional Rehabilitative Services, staff has the skills, experience, qualifications and licensure to provide such care services in respective jurisdictions.

Evaluation/Documentation

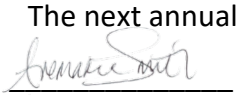
Demonstrated competencies, knowledge, and skills must be available upon request (e.g. participation in training, formal supervisory review, direct observation, case review, etc.)

V. 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).

VI. APPROVAL & SIGNATURES

This service standard has been reviewed and approved on January 2, 2024.
The next annual review is July 31, 2025.



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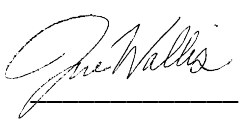

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