

ACHIEVING EXCELLENCE

**STANDARDS OF CARE AND BEST
PRACTICES FOR HIV/AIDS
SCATTERED SITE SUPPORTIVE HOUSING**

Funded by the Massachusetts Department of Public Health HIV/AIDS Bureau

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INTRODUCTION

INTRODUCTION



We are pleased to present *Achieving Excellence: Standards of Care and Best Practices for Scattered Site, HIV/AIDS Supportive Housing*. This updated volume of Standards of Care for HIV/AIDS housing and service delivery is the result of the hard work and energy of Massachusetts HIV/AIDS supportive housing providers, residents, and local funders in collaboration with the AIDS Housing Corporation (AHC). This publication should serve as a useful resource for your programs in creating or improving existing HIV/AIDS supportive housing.

The AIDS epidemic of today looks very different than it did when the first supportive housing programs targeting people with HIV/AIDS opened over a decade ago. Many people with HIV/AIDS are able to manage their illness and are living longer due to successful new HIV treatments, resulting in decreased turnover in housing programs; many residents of HIV/AIDS housing have a variety of co-occurring illnesses, such as substance use, mental illness, and Hepatitis C, which impact their lives and tenancies as much or more than HIV/AIDS; and the development of new housing programs has slowed. As the epidemic and the housing needs of people with HIV/AIDS evolve, it is increasingly important to revisit the best practices for providing supportive housing and update our Standards of Care accordingly. *Achieving Excellence* is designed as a revised version of the first Standards of Care manual published in 1997.

BACKGROUND

In the field of supportive housing, HIV/AIDS housing is a relative newcomer. In Massachusetts, housing programs targeting people with HIV/AIDS opened in the 1990s by piecing together different funding streams to respond quickly to the crisis of homelessness and unsafe housing situations among people with HIV/AIDS. Unlike many other forms of supportive housing for disabled populations, there are no regulatory requirements for HIV/AIDS housing. While this allows for creativity and flexibility in service delivery, it also necessitates developing standards for service delivery. In 1997, AHC and the Massachusetts Department of Public Health (DPH) published *Doing It Best: The Practice of Supportive Housing for Persons with HIV/AIDS in Massachusetts*. This publication offered standards, recommended practices, and outcomes to guide programs in the provision of housing and supportive services. These standards were intended to be used by both congregate and scattered site housing programs.

Once *Doing it Best* was published, housing providers that received funding from DPH were required to adhere to these standards and demonstrate that they were

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doing so. To document this effort, DPH undertook an innovative approach to assessment: facilitated peer-evaluations in which providers would evaluate themselves regarding their compliance. During the pilot phase of the peer evaluations, it became clear that the standards would need to be altered to provide a better fit for scattered site housing programs. Several housing providers worked with AHC and DPH staff to modify the standards so they could also be used as part of the peer evaluation process.

AHC was contracted by DPH to facilitate the peer evaluations. Feedback was collected in both formal and less formal ways. Informally, providers (including program directors and case managers) and residents often had comments about the standards, practices, and outcomes found in *Doing It Best*. Additionally, AHC conducted focus groups in July 2001 to hear what providers had to say about the peer evaluations process and the standards themselves. Ultimately, this information was included in a report which AHC submitted to DPH in the spring of 2002. Simply put, there was a consensus that the standards needed updating to reflect changes in the epidemic and thinking about the field of supportive housing.

HOW THE STANDARDS WERE REVISED

AHC staff began revising the standards by incorporating the feedback which it received during the peer evaluation meetings and the July 2001 focus groups. The next step was to work with representatives from DPH and the Boston Public Health Commission (BPHC), two of the primary funders of services in AIDS housing programs in Massachusetts. Over the course of five months, this group examined the standards and practices in exacting detail. The draft was edited to eliminate repetition, increase the clarity of the text, and simplify the standards and practices.

HIV/AIDS supportive housing providers and residents were instrumental in updating the standards. Seven providers volunteered their time by participating in committees that comprehensively questioned, edited, and re-wrote sections of the Standards of Care. In addition, providers also assisted in the collection of resident feedback by convening small groups to examine several standards. This feedback was shared with AHC, DPH, and BPHC staff.

Finally, certain standards (Tenant Selection, Due Process, and Resident Evictions) have been subject to additional review from fair housing specialists.

GOALS OF THE STANDARDS OF CARE

Many of the goals of creating the original Standards of Care hold true for this edition. These goals are as follows:

- To articulate areas of philosophical consensus regarding the broad mission of HIV supportive housing.
- To establish measures of performance and a series of practices toward which providers can strive in an effort to improve the quality of services and models of care in HIV housing.
- To create a public statement for the benefit of consumers and other stakeholders defining the intent of HIV housing and the manner in which these diverse housing services are organized along a coherent continuum-of-care so prospective residents can make informed choices.
- To recommend practices and strategies for achieving the goals of HIV housing in an educational format where providers can selectively choose among ideas most suitable to their unique context and model of HIV housing.
- To enhance the ability of funders to assess the performance of their contracts with HIV/AIDS housing organizations by setting out a clear set of expectations, a common vocabulary, and a universal framework for excellence in service delivery.
- To capture the collective wisdom of experienced HIV housing providers as well as other organizations involved in fields of special needs housing in a format conducive to sharing information across the boundaries traditionally separating peer organizations.

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and publisher are solely responsible for accuracy of the statements and interpretations contained in this publication. Such interpretations do not necessarily reflect the views of the Government.”

AHC also wishes to thank the many providers and residents of HIV/AIDS supportive housing who contributed their time and ideas to *Achieving Excellence*. Special thanks to:

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Alexis Breiteneicher and Rachel Kogan served as principle editors at AHC.

ABOUT AIDS HOUSING CORPORATION

AHC is New England’s leading provider of technical assistance to AIDS housing organizations. Founded in 1991, AHC has worked to create a continuum of affordable, supportive housing options for people infected and affected by HIV. AHC is dedicated to the development and support of AIDS housing programs throughout New England, though our base of work is in Massachusetts. Our activities fall into the following categories:

- Project development and support
- Needs assessment and community planning
- Program evaluation
- Training and education
- Advocacy and community systems planning

For more information, please consult our website: www.ahc.org

STANDARDS

RESIDENTIAL SPACES



INTRODUCTION

Special consideration is necessary to meet the needs of clients who experience the chronic conditions associated with HIV disease. For them, achieving and sustaining independence is enhanced by the existence of accessibility features in their homes and the overall flexibility of the spaces where they live.

STANDARD

Plans are implemented to make sure that residential spaces are responsive to the specific accessibility needs of persons living with HIV disease. Amenities and design features reflect consideration for the possibility of some clients experiencing weakness, fatigue, motor impairment, visual impairment, mobility problems, and other physical difficulties.

CORE PRACTICES

1. The provider complies with the Americans with Disabilities Act by addressing the following issues:
 - Accessibility of programs and services
 - Accessibility of the building in which services are delivered.
 - Accessibility of communications for the deaf, hard-of-hearing, or otherwise communication disabled
 - Accessibility of visual and print materials for people unable to read or see due to a disability
 - Accessibility of eligibility criteria such that persons with disabilities are not screened out
 - Accessibility of employment such that qualified persons with disabilities are not discriminated against in employment practices

2. The provider researches accessibility requirements that may be relevant to its HIV housing program. Most HIV housing programs will have an obligation under one or more of the following laws:
 - The Federal Fair Housing Amendments Act - applies to housing with four or more units built before March 13, 1991.
 - Section 504 of the Federal Rehabilitation Act of 1973 - applies to all housing providers receiving public funds.

RESIDENTIAL SPACES

- Americans with Disabilities Act Title II (State and Local Governments) - applies to all housing owned, operated, or funded by state or local government.
- Americans with Disabilities Act Title III Public Accommodations - applies to all housing owned or operated by private entities (including non-profit organizations) and/or housing that has supportive services attached to it.

OUTCOME

Clients with varying levels of health experience an enhanced range of independence. Clients with fluctuating or declining health status are able to remain living in their homes throughout most stages of illness and have features of their homes adapted to their needs.

ADDITIONAL GUIDANCE

1. The provider understands that compliance with one accessibility law does not supersede another. In all cases, the strictest regulations and standards must be followed.
2. The provider makes certain that the office space where clients are seen is physically accessible for someone using a wheelchair.
3. When not supplied by the client, the provider attempts to assist in acquiring basic household items such as linens, dishes, and waste baskets, etc.
4. On an as needed basis, the provider attempts to ensure that simple accessibility features are installed in the homes of clients who experience periodic or chronic disabling conditions.

PROGRAM OBLIGATIONS REGARDING PROPERTY MANAGEMENT

INTRODUCTION

In scattered site housing, service providers will be required to work with property management companies. In some situations, there may be communication problems and conflicts between the private management company and the supportive housing community. All HIV housing providers need to ensure that property management is performed well and is coupled with thorough, day-to-day practices to safeguard the well-being of clients.

STANDARD

The service provider assists the client in initiating conversations with property management about issues pertaining to a client's home and will intervene when necessary. As a result, the client's home is maintained in a safe and hygienic condition. Clients requiring help or guidance in cleaning their personal spaces are linked with such assistance.

CORE PRACTICES

1. The provider helps to facilitate a client's transition into housing by offering guidance about how and when to initiate actions with the landlord or property manager and advocating for the client's tenancy needs.

OUTCOME

Clients are protected from hazards and risks to their health and safety brought on by unsanitary conditions or avoidable maintenance problems in their homes. Clients live in a stable environment that can remain their permanent home.

ADDITIONAL GUIDANCE

1. The provider arranges for house cleaning assistance for clients who can not maintain their own apartments.

OCCUPATIONAL SAFETY AND UNIVERSAL PRECAUTIONS



INTRODUCTION

The term “universal precautions” refers to the simple but essential practices which all public institutions use to prevent transmission of disease. These procedures are implemented under the presumption that blood and body fluids from any source are to be considered potentially infectious. The Occupational Safety and Health Administration (OSHA) has regulations aimed at preventing the spread of HIV and other diseases in public settings where clients or staff could be put at risk.¹ The HIV service provider must learn and integrate these protocols and use specific strategies that make sense for their programs.

STANDARD

The provider adheres to universal precautions and relevant OSHA regulations so as to minimize the exposure of staff to blood-borne pathogens and other potentially infectious materials. Staff are trained in all relevant practices and are provided with the supplies necessary to carry out these procedures on a day-to-day basis.

CORE PRACTICES

1. All staff receive training in universal precautions. New staff members receive training in universal precautions before they begin work. This information is linguistically and culturally accessible to all staff.
2. Protective barriers, such as rubber gloves, are used for all tasks where occupational exposure may occur.

OUTCOME

Staff are protected from the risks of exposure to bloodborne pathogens.

¹ For more information, please see the OSHA website (www.osha.gov) for the Bloodborne Pathogens Standard 1910.1030 (updated in 2001).

OCCUPATIONAL SAFETY AND UNIVERSAL PRECAUTIONS

ADDITIONAL GUIDANCE

1. Special consideration is given to the presence of pets in the home, acknowledging both their emotional benefits and their potential for carrying organisms not well tolerated by people living with AIDS. Staff work with clients to increase awareness of concerns related to pet ownership (infectious organisms are present in animal wastes, bird cages, cat litter boxes and fish tanks) and practical ways for dealing with these concerns.
2. Clients who use syringes are trained in their safe disposal. Precautions are taken by staff and clients to prevent injuries from hypodermic needles. Special containers for disposing hypodermic needles are available for clients to keep in their homes.

TUBERCULOSIS CONTROL



INTRODUCTION

The immunological suppression associated with HIV disease calls for providers to be particularly vigilant with regard to tuberculosis (TB). Statistically, people with HIV disease are disproportionately infected with TB. Providers should be aware of clients who have been treated for active TB but who are out of compliance with the complete treatment regimen.

STANDARD

The provider has a TB protocol that addresses testing, prevention, and treatment for clients and staff. The provider ensures that appropriate professionals and personnel execute the protocol in a non-punitive manner.

CORE PRACTICES

1. Every client is screened for TB as part of the intake process.
2. Staff are screened for TB upon starting their jobs and every year thereafter.
3. When a client is diagnosed with active TB, the provider works with a TB clinic to direct the course of treatment. The provider should discuss with the TB clinic the feasibility of a client remaining at home.
4. When a client or staff member is known to have active TB, efforts are made to identify all staff and clients who may have been exposed. If their TB tests are not up to date, they should be re-tested immediately.

OUTCOME

TB infection is minimized through consistent detection and treatment. Staff use their awareness of the signs and symptoms of TB to monitor their own health status.

ADDITIONAL GUIDANCE

1. The provider maintains an ongoing relationship with the local public health authorities to access the most current material on the prevention and treatment of TB.

RELIGIOUS FREEDOM AND SPIRITUAL ACTIVITIES



INTRODUCTION

The power of religious beliefs and spiritual practices to help people living with HIV disease cope with the stresses and anxieties of their lives is widely recognized. In fact, many faith-based organizations provide HIV/AIDS services including housing. Regardless of the nature of the sponsoring organization, all HIV/AIDS housing programs must strive to be open, welcoming, and comfortable to all clients.

In addition to complying with fair housing law, which, among other things, prohibits discrimination based on religion, providers are expected to be free from religious and spiritual influences, and sensitive and respectful to the diverse range of religious and spiritual beliefs of the clients.

STANDARD

The spiritual and religious beliefs of all clients are protected and respected. Clients' religion, personal beliefs, and willingness to participate in religious activities are not factors in admitting or denying applicants. Staff do not offer, initiate, encourage or discourage religious or spiritual instruction, counseling, or worship. The provider makes available, upon request from the clients, information about religious and spiritual instruction, counseling, services, and worship in the community.

CORE PRACTICES

1. During tenant selection, the provider does not ask questions of prospective clients regarding religion, personal beliefs, and willingness to participate in religious activities.
2. Participation in any form of spiritual care or counseling offered in connection with the sponsoring organization is voluntary. The agency assists clients with accessing religious counseling and pastoral care, when desired. Staff members are not among those who perform such voluntary counseling or care.

RELIGIOUS FREEDOM AND SPIRITUAL ACTIVITIES

OUTCOME

Clients participate in housing programs that are open, welcoming, and comfortable to all regardless of religious or spiritual beliefs. All clients are able to engage privately in their chosen religious and spiritual activities. Respect for clients with different belief systems is ensured.

PHYSICAL SAFETY AND BEHAVIOR MANAGEMENT



INTRODUCTION

It is important for providers to address concerns related to the physical safety of clients. The extent of potential safety concerns necessitates the development of procedures for approaching all aspects of service delivery within a safe framework.

STANDARD

The provider utilizes a framework for service delivery that emphasizes the safety of clients and staff as a paramount concern. Emergency procedures and emergency contacts are made available to staff in an effort to prevent, to the best of the staff's abilities, the escalation of incidents, and to react effectively to those incidents that do escalate. Staff document incidents such as fights, accidents, and medical emergencies and follow up with routine protocols for notifying authorities and superiors.

CORE PRACTICES

1. The provider develops written policies and procedures related to:
 - Weapons
 - Abusive/threatening behavior
 - Sexual harassment
 - EmergenciesThese policies are made available to clients and staff.

2. The following information is readily available to staff:
 - Telephone and pager numbers of backup personnel, when available
 - Emergency contact names and telephone numbers for each client, including medical providers
 - First aid, CPR, and choking procedures

PHYSICAL SAFETY AND BEHAVIOR MANAGEMENT

OUTCOME

The safety of clients and staff is maximized through the implementation of preventive safety measures.

ADDITIONAL GUIDANCE

1. Measures are taken to protect the safety of staff who visit clients in scattered site HIV housing. Strategies may include:
 - Cell phones made available for all staff who perform home visits.
 - Conducting home visits in pairs
 - Meeting clients in public places such as coffee shops, libraries, etc.
 - Use of detailed schedules submitted by field staff to supervisors each day
 - Periodic check-ins between field staff and supervisors throughout the course of the day
2. The provider is aware of procedures for requesting an emergency mental health intervention and assessment when a client:
 - Is considered an immediate threat to others or him/herself
 - Will not participate in voluntary clinical assessment.The provider contacts the local police department to request this emergency service.
3. Incident reports should serve as proof of the provider's responsiveness to problems by documenting all calls to the police, calls for an ambulance, and the filing of restraining orders.

INTRODUCTION

Many HIV/AIDS housing programs target specific kinds of households. Some target families with dependent children, while the majority of providers work with adult, single-person households. However, many of these adults are, in fact, parents whose children reside elsewhere. Frequently, providers will become peripherally involved in issues related to family life. All providers must develop the skills to meet the needs of clients with children and identify appropriate community resources.

STANDARD

In serving families, the provider utilizes a model of service delivery that emphasizes comprehensiveness and flexibility. Providers that serve parents address issues such as domestic violence, the safety of children and other family members, and economic issues from the needs assessment period through the service delivery stage. The provider monitors and reports signs of potential abuse and neglect of children to state authorities and law enforcement agencies.

CORE PRACTICES

1. The provider develops policies related to reporting possible abuse or neglect of any child known to the provider. Clients are informed of the staff's legal obligation to report suspected abuse. This policy instructs staff on the following:
 - Signs that may indicate abuse or neglect
 - The need to minimize negative affects of such a report on the provider's relationship with the suspected abuser
 - A local hotline number for reporting suspected abuse or neglect
 - An after-care plan to ensure the safety of all family members
2. Needs assessments and individualized service plans for adults living alone and for those living with children address family issues. Service plans outline the intended scope of the provider's involvement with a client's family members and specific goals to be achieved.

OUTCOME

Residential stability is enhanced in HIV/AIDS housing. Family disruption is minimized through the appropriate delivery and referral to services and assistance for all members of the family.

ADDITIONAL GUIDANCE

1. The provider emphasizes the comprehensiveness of service delivery for clients.
2. The provider develops lists of referrals for family-related services to which parents can be directed. Examples include:
 - Names of licensed day care providers
 - Parenting stress hotlines and support groups
 - Support groups for children of persons with HIV/AIDS
 - Local public school information
 - Head Start information
 - Names of therapists who specialize in family practice
 - Summer camps and after-school providers
 - Transportation assistance
 - Parenting skill classes
3. Providers are trained in all public entitlements for which residents may be eligible. Early in a family's stay, referrals are made for the following entitlement resources:
 - Temporary Assistance for Needy Families (TANF) program
 - Women Infants and Children (WIC) program
 - Food Stamps program
 - Supplemental Security Income (SSI) program
4. When clients experience crises (such as relapse in drug use, suicidality, medical problems, etc.), the provider works with relevant agencies to coordinate crisis intervention and a care plan for all affected family members.

STAFF HIRING, ORIENTATION AND TRAINING



INTRODUCTION

Investing time and resources into a strong orientation and training for staff is an efficient strategy for fostering quality in HIV housing. Furthermore, providing an adequate orientation and training will help to minimize staff turnover.

STANDARD

Staff members and other individuals providing services are well informed about the scope of their job responsibilities, agency policies, and receive adequate training to execute all responsibilities with confidence and skill. Staff have the qualifications to meet the needs of clients and they reflect the diversity of the populations that they serve.

CORE PRACTICES

1. The provider uses channels for staff recruitment that are likely to attract employees who reflect the cultural and linguistic diversity of the target population.
2. The provider has a policy for recruiting and hiring staff. Newly hired staff will be oriented within six weeks and will begin initial training within three months.
3. Screening practices for new employees ensure that staff have:
 - Appropriate skills, experience, and licensing certifications to perform assigned responsibilities
 - Positive references from other employment experiences, if possible
 - Criminal background histories that are consistent with agency and/or funder regulations
4. The provider develops a staffing pattern that is consistent with the particular model of housing it operates.

STAFF HIRING, ORIENTATION AND TRAINING

5. The provider develops a personnel manual which is made available to all employees. In addition, providers have a training manual or other similar resource for the orientation of new staff. It contains the following:
 - Mission statement of the agency or provider
 - Literature about the sponsoring agency, when applicable
 - Personnel and program policies and procedures
 - Samples of properly-completed paperwork, including reports to funders
 - Organizational chart(s)
 - Explanation of performance review processes
 - Orientation to Standards of Care for HIV/AIDS housing
6. Providers encourage new staff to attend trainings that will benefit them in their roles.

OUTCOME

Opportunities and incentives for skill building, training, and growth of responsibility are provided to staff. Staff are well-trained and knowledgeable about issues related to their jobs. Clients receive help from well-trained and supervised staff such that they improve their ability to achieve housing success.

ADDITIONAL GUIDANCE

1. In the first six months of employment, new staff will benefit from training in the following topic areas, as appropriate:
 - First Aid, choking procedures, and CPR
 - HIV/AIDS drug treatments and associated protocols/regimens
 - AIDS-related illnesses
 - Basic counseling skills
 - Conflict resolution
 - Use of objective, non-judgmental language in speaking to clients and to other staff and outside service contacts about clients
 - Working with clients with substance use histories
 - Dealing with mental health crises
 - Cultural competence

STAFF HIRING, ORIENTATION AND TRAINING

2. As program capacity allows, staff are encouraged to participate in in-service trainings or are provided with information and referrals for similar services that are available in the community.
3. The provider creates clear and detailed job descriptions for every staff position.

STAFF SUPERVISION AND EFFECTIVE MANAGEMENT



INTRODUCTION

Retaining staff is critical to the functioning of HIV/AIDS housing programs. Staff turnover can create chaos and inefficiency for the provider and a sense of loss for clients. Staff require organized leadership and regular supervision to be effective. When supervisors anticipate the staff needs and provide adequate support, they help sustain positive morale and keep employees in their jobs.

STANDARD

The provider offers the resources necessary for staff to increase their effectiveness on the job. Systems of supervision are in place to support staff in developing their knowledge, effectiveness, and creativity. Supervisors seek to provide both guidance and support to their employees.

CORE PRACTICES

1. Staff are evaluated annually according to the criteria required to function in their roles. Both the supervisor and staff member sign the evaluation report. If staff members decline to sign, the report indicates the extent to which they participated in the evaluation process.
2. Direct service staff receive one-on-one or small group supervision on a consistent basis. The frequency of supervision will vary, ranging from weekly meetings in intensively serviced settings to monthly meetings at other providers.
3. Direct service staff have access to quality clinical supervision through experienced, trained, and licensed supervisors.

STAFF SUPERVISION AND EFFECTIVE MANAGEMENT

4. The provider has a policy for disciplining and firing employees. This policy outlines a series of progressive steps that include, as appropriate, the following:
 - Providing specific feedback to employees pertaining to poor job performance
 - Presenting employees with signed and dated summaries of the employer's concerns and expectations for change
 - Providing employees with written warning(s) of the potential for termination, with deadlines for improving performance
 - Terminating employees in face-to-face meetings with senior staff
 - Maintaining written records of all communications
5. Staff meet all agency and/or funder obligations for maintaining a drug-free workplace. Staff who experience drug-related problems are offered assistance in accessing treatment through their employee benefits package and developing a plan, when appropriate, for returning to work.

OUTCOME

Clients receive consistent services, to the greatest extent possible, from staff members whose competencies are reinforced and enhanced on the job. Staff responsibilities are manageable and staff turnover is minimized.

ADDITIONAL GUIDANCE

1. Staff receive a preliminary evaluation after the first six months of employment.
2. Staff receive at least one hour of regular supervision and one hour of clinical supervision per month.
3. Supervisors have access to training in basic supervisory skills. Their instruction includes special attention to how to manage employees in the context of HIV/AIDS housing. For example, supervisors learn to:
 - Outline clear expectations and limits with direct service staff
 - Respond to emotional needs of direct service staff


STAFF SUPERVISION AND EFFECTIVE MANAGEMENT

- Conduct performance evaluations
 - Cultivate positive morale
 - Role model-appropriate interaction with clients
 - Interview prospective employees
4. Supervisors communicate clear boundaries regarding the appropriateness of the staff's focus on workplace-related emotional concerns and the inappropriateness of allowing issues related to the staff's personal lives to dominate the workplace.
 5. The provider has a procedure to ensure suitable staff coverage when regular staff are absent or when staff positions are vacant. Strategies can include:
 - Using relief staff
 - Requiring staff members to carry emergency pagers during uncovered shifts
 - Using human services temporary employment agencies
 6. Personnel practices are designed to balance the potentially isolating nature of direct service work and may include:
 - Staff retreats
 - Group meetings
 - Consistent supervision of all direct service staff
 - Opportunities for self-care, such as mental health days and flexible work hours
 - Mental health services
 7. Group supervision and staff meetings do not take the place of private, individual supervision.
 8. Supervision meetings include:
 - Problem solving for specific, client-related issues
 - Mentoring/ skill development
 - Assessments of staff's need for emotional support
 - Feedback on job performance
 - Feedback to supervisor on job satisfaction
 - Exchange of peer advice and support

STAFF SUPERVISION AND EFFECTIVE MANAGEMENT

9. Supervisors practice consensus decision making with staff as feasible. Supervisors understand that the success of many supervisory decisions will be contingent upon buy-in from the staff who are responsible for executing those decisions.
10. Senior staff with management responsibilities have access to management training and support. Recommended areas of instruction for managers include:
 - Organizational development
 - Staff supervision skills
 - Financial management/budgeting
 - Effective management practices
 - Hiring, disciplining, and firing practices
 - Leadership
 - Consensus decision making techniques, including group facilitation skills

CLIENTS' RECORDS



INTRODUCTION

The material included in client records is often driven by funding requirements. To this end, record keeping systems are tailored to the special character of the HIV/AIDS housing field. The provider has a clear rationale for all information which is maintained in client records.

STANDARD

The provider's system of maintaining client-related records is tailored to meet the unique characteristics of HIV supportive housing. The record system captures only essential information and does so efficiently and thoroughly. Staff find the system manageable.

CORE PRACTICES

1. An individual written or computer file pertaining to each resident is maintained. Providers who choose to use computer-based record keeping add systems for securing records against inappropriate access.
2. Standard program records are tailored to meet the precise need for information required by the provider and its funders, and are not excessively intrusive without programmatic necessity. Standard program records include the following:
 - Income verification
 - HIV diagnosis verification
 - TB test results
 - Needs assessment
 - Individualized Service Plan
 - Emergency contacts
 - Medical information & contacts
 - Case notes
 - Programmatic agreement, if applicable
 - Current release of information forms
 - Signed grievance procedure policy
 - Signed confidentiality policy
 - Signed list of clients' rights
 - Discharge forms, if applicable

CLIENTS' RECORDS

3. The provider has a policy for clients to review their records, upon request, within a reasonable amount of time.

OUTCOME

Clients rely on the provider to maintain essential personal information about them, but not to unnecessarily intrude on their privacy through record keeping. The experience of living in a scattered-site HIV/AIDS supportive housing program is distinguished, in its record keeping systems, from life in more institutional or clinical settings.

ADDITIONAL GUIDANCE

1. The system for maintaining client records parallels the provider's goals and objectives. Treatment or clinically-oriented case notes are only appropriate for treatment settings. Mental health counselors who perform on-site therapy maintain separate notes from primary client records.
2. The provider updates notes on services rendered on a regular basis. A few methods for documenting service delivery included:
 - Entries added to traditional case notes indicating the delivery of a particular service
 - A chart with the names of all clients and check-off boxes for types of services rendered
3. Staff write some form of exit summary for clients who leave the HIV housing program. Summaries can include a record of services delivered to the client or an after-care plan.
4. Case records pertaining to individual clients are recorded in objective language and are limited to accounts of fact and behavior.
5. Staff are trained to make entries in client records in a universal language that is common to all entries and that fits standardized limits as to appropriate content.

TENANT SELECTION



INTRODUCTION²

Federal, state, and local fair housing laws apply to supportive housing providers regardless of whether they identify themselves as housing or a program. Providers must understand and abide by these laws.³

STANDARD

The party conducting tenant selection demonstrates a commitment to equal opportunity and fair housing laws in its admissions practices. Efforts are made to affirmatively market the housing and housing service components to all eligible individuals, including those who might have difficulty learning about it through traditional channels and formats.

CORE PRACTICES

1. The service provider invites any person who may be eligible to apply for housing.
2. The landlord/owner devises a set of clear written tenant selection criteria concerning (1) eligibility, which is determined by the funding source; and (2) suitability, the ability to comply with the terms of the lease. Eligibility is limited to programmatic requirements in which all tenants meet certain criteria, such as having a low income, an HIV/AIDS diagnosis, service needs, or homelessness. ***Tenant selection activities are limited to inquiries that determine whether an applicant is eligible for the housing and will be able to comply with the terms of the lease.***

²For specific questions on the legal issues of tenant selection, please consult your agency's legal counsel. Two additional resources which were used to develop this standard include *Between the Lines* published by the Corporation for Supportive Housing (2001) and *A Handbook on the Legal Obligations and Rights of Providers of Service- Program Housing Under Federal and State Disability Fair Housing Laws*, Massachusetts by Debbie Piltch and Ann Anderson (1997).

³A client may be considered a tenant if some or all of the following apply: "(1) if a lease exists; 2) length of stay; 3) whether the place is the person's home, or if he/she has another residence; 4) whether the person pays fees or rent; 5) whether the person has control over the dwelling." (Piltch & Anderson) Agencies are advised to consult legal counsel before determining if a client is a tenant or not.

TENANT SELECTION

3. The landlord or staff selecting tenants structures the decision to accept or deny an applicant around eligibility and suitability. A denial may be due to any of the following reasons:
 - Ineligibility, i.e., the applicant does not require services; does not have an HIV/AIDS diagnosis; or is not homeless or at risk of homelessness⁴
 - Not suitable for housing, i.e., poor credit history;⁵ previous evictions; incomplete or false information presented in application; negative reference by present/ former landlord; history of violence; current illegal use of a controlled substance; history of certain criminal convictions; inability to pay rent and other fair charges in a timely manner; inability to care for and avoid damaging the units; inability to respect the rights and enjoyment of others
4. The service provider and the landlord/owner ensure that the steps associated with tenant selection and client intake are two distinct activities. These activities may be concurrent if they are conducted by separate parties or organizations. In dividing the phases into two steps, the landlord/ owner avoids inappropriately introducing information gleaned from the needs assessment process in making tenant selection decisions.
5. Scrutiny of applicants' abilities to meet essential lease agreements is uniformly and consistently applied to all applicants. If, for example, the landlord/owner runs a credit or criminal history check on one applicant, all applicants must be similarly checked.
6. It is illegal to ask about the nature or severity of a person's disability in tenant selection. However, it is permissible to ask if a person has a disability, such as an HIV/AIDS diagnosis, only if it is necessary to determine eligibility.⁶ The landlord/owner may not make assumptions regarding an applicant's ability to comply with the terms of the lease based on the nature or severity of an applicant's disability.
7. The landlord/owner may not deny an applicant due to an inability to live

⁴Ineligibility is determined by the funding stream for the housing subsidy. All landlord/ owners and service providers should be aware of eligibility requirements of individual funding sources.

⁵A landlord/owner may not deny a client housing due to a lack of a credit history.

⁶Landlord/owners and service providers should explain to applicants that questions about disability are asked solely to determine eligibility and will be kept completely confidential.

independently. Rather, the landlord/owner may consider the applicant's ability to meet the essential obligations of the lease agreement with or without a reasonable accommodation.⁷

8. If an applicant has a disability and asserts that he/she cannot comply with the terms of the lease as a direct result of his/her disability, the provider should consider whether a reasonable accommodation will enable the applicant to comply with the terms of the lease. The landlord/owner can only reject such a client if the landlord/owner can demonstrate that the accommodation would result in a fundamental change in the nature of the housing program or would pose an undue financial and administrative burden.
9. If it is determined during the application process that the applicant has a bad tenancy history or criminal record which is due to a disability, such as a history of illegal drug use, the applicant may request a reasonable accommodation which then must be considered by the provider. The reasonable accommodation will need to establish that: a) the bad housing or criminal history was a direct result of substance use, b) the applicant is not currently using a controlled substance, and c) will be able to comply with the terms of the lease.
10. The landlord/owner and/or the service provider develops an equal opportunity statement that is used in all advertisements and literature related to marketing the housing resource.
11. Applicants who are found to be either ineligible or unsuitable are provided with a written explanation as to why they were denied housing. This notice includes contact names and phone numbers for appealing the rejection as well as for local fair housing offices, and, if the housing is supported by federal funds, the HUD Fair Housing Discrimination Complaint Hotline.⁸ The applicant is notified that he or she has the right to appeal the rejection.

⁷ There are organizations that offer training on reasonable accommodations. In Massachusetts, Mass Housing holds quarterly trainings: "Reasonable Accommodation for People with Physical and Mental Disabilities." See www.masshousing.org for more details

⁸ Please see standard on Due Process for a more detailed explanation of what is due to an applicant when the applicant is denied or loses housing.

TENANT SELECTION

12. Applicants may choose to file an appeal if they are able to provide evidence that the reason for the rejection is a direct result of a disability and a reasonable accommodation is necessary for the applicant to be lease-compliant. The appeal should be filed within a timeframe indicated by the rejection letter. The landlord/owners should then consider applicants' requests and determine whether or not their requests can be accommodated reasonably. A final decision is put in writing by the landlord/owner. The landlord is not required to hold open a unit while the appeal is being filed. If the appeal is successful, then the applicant is placed on the waiting list if there are no units available at that time.
13. A fair procedure is developed and consistently followed for managing applicants who apply to the landlord/ owner or service provider at times when there are no openings. Possible systems include a chronological waiting list where the first applicants to apply are first to be offered housing, or a lottery at periodic intervals in the year.
14. The landlord/owner recognizes its obligation to comply with relevant federal, state, and local fair housing laws in selecting tenants for housing. Applicable laws include but are not limited to:
 - Title VIII of the Civil Rights Act of 1968
 - 1982 Civil Rights Act of 1866
 - 1981 Civil Rights Act of 1866
 - Rehabilitation Act of 1973

OUTCOME

All eligible applicants have equal access to HIV/AIDS housing. The admissions procedures are systematic and fair for all applicants. The spirit and practice of fair housing laws are integrated into admission procedures such that screening of potential applicants include questions related only to eligibility and suitability for housing.

ADDITIONAL GUIDANCE

1. In assessing an applicant's ability to uphold essential obligations of a lease agreement, the landlord/owner may request the applicant's authorization to consult multiple sources, such as:
 - Previous landlords
 - Credit companies
 - Employers
 - Probation officers
 - Social workers
 - Client programs from which the applicant has graduated⁹
2. The landlord/owner avoids the practice of requiring that all applicants with a history of illegal drug use be drug-free for a set period of time before moving into the housing program.
3. The landlord/owner may directly ask all applicants if they are currently and illegally using a controlled substance and if they have been convicted of the illegal manufacture or distribution of drugs. Verification that the applicant is not currently using illegal drugs and will be able to comply with the terms of the lease in the housing program can be obtained from the following sources:¹⁰
 - A certified substance use counselor
 - A self-help organization
 - A voluntary interview with a substance use screening team
 - A voluntary urine screen conducted in keeping with National Institute of Drug Abuse Guidelines¹¹
 - A residential drug treatment program
 - A clergy member or other reliable personal reference
4. When possible, the landlord/owner has tenant selection policies reviewed by an attorney for compliance with fair housing laws.

⁹ Previous client programs may be consulted when there have been requirements related to tenancy that would provide relevant information about the applicant's ability to uphold the lease.

¹⁰ All personal references must be at the recommendation of the applicant and may not be determined by the housing provider or landlord/owner.

¹¹ The cost of drug testing must be paid for by the housing provider and may not be passed on to applicants to the housing program.

TENANT SELECTION

5. A committee of individuals is designated to oversee management of waiting list practices to ensure fairness, impartiality, and compliance with federal and state anti-discrimination laws in selecting residents.

CONFIDENTIALITY



INTRODUCTION

HIV housing providers have an ethical responsibility to keep all personal information about individual clients confidential. There are strong legal, professional, and community standards related to the safekeeping of information regarding, among other things, HIV status, substance use, and mental health status.

STANDARD

All staff adhere to professional practices and ethics that provide for confidentiality and security of personal information related to clients. The provider conducts ongoing educational opportunities and training for staff on confidentiality procedures.

CORE PRACTICES

1. The agency has a policy regarding confidentiality which is available to clients and staff. Clients sign documentation indicating that they have been informed of this policy. This policy addresses, but is not limited to:
 - Issues related to the conduct of staff and clients around confidentiality
 - Protocols for breaches of confidentiality for staff and clients
2. The provider helps safeguard information pertaining to clients from loss, destruction, tampering, and unauthorized use. Practices include:
 - Keeping client records out of public view
 - Maintaining client related files in a locked space
 - Requiring that staff only view client records within the confines of their offices
3. Staff do not discuss clients in any public venue.
4. The provider uses releases of information (written authorization for disclosure of information) before discussing clients or sharing any personal information about them with all outside service contacts or any other party. These release forms include the following information:
 - Client's full name
 - Entity to whom disclosure is authorized

CONFIDENTIALITY

- Type of information being disclosed
 - Time period during which the release is effective
 - Statement of the voluntary nature of the release
 - Signature of the client or other authorized individual
 - Signature of a staff person
 - Date
5. The provider does not use identifying information in contract reports to funding organizations

OUTCOME

Clients receiving services from the provider have confidence that information about them will not be disclosed without their consent.

PROTECTING CLIENTS' RIGHTS

INTRODUCTION

While scattered site housing programs tend not to be overly regulatory, clients may have to comply with certain program requirements. Nevertheless, most providers of HIV housing should identify themselves, first and foremost, as housing rather than as programs. Measures to promote and protect clients' rights are an important component of housing programs.

STANDARD

Clients are ensured personal privacy, control over their homes, and a set of clearly defined individual rights that are maintained while living in a supportive housing program.

CORE PRACTICES

1. Before choosing to live in an HIV/AIDS housing program, applicants are informed of the following:
 - Programmatic guidelines and client responsibilities, which should be presented in writing
 - The scope of services and clients' expected participation in them
 - Requirements for signing of releases of information and other documents
 - Tenant and lease responsibilities
 - Details of the program's substance use policies, including harm reduction philosophy, if applicable.
2. The provider has a written list of basic client rights which is made available to clients.
3. Programs must ensure access to services for clients with limited English skills. Family and friends are not considered adequate substitutes for interpreters. If a client chooses to have a family member or friend as an interpreter, the provider obtains a written and signed consent in the client's primary language.

PROTECTING CLIENTS' RIGHTS

5. Any forms of assistance with personal finances offered by the provider to clients are voluntary. Staff do not keep or bank money on behalf of clients, even in cases where clients make such a request, as this practice presents problems related to responsibility in the event of a client's relocation or death.

OUTCOME

Clients are able to exercise their rights while living in supportive housing.

ADDITIONAL GUIDANCE

1. Goods and services typically offered by the provider are guaranteed to all clients regardless of their compliance with programmatic expectations. Services are not withheld for behavioral management purposes.

CONSUMER PARTICIPATION IN DECISION MAKING



INTRODUCTION

A unique strength of the field of HIV/AIDS services is its tradition of consumer activism and control in policy making. Weaving this philosophy into the day-to-day operations of HIV/AIDS housing is a unique challenge with special rewards. There are multiple ways for the provider to involve clients in the governance of HIV/AIDS housing programs. Relationships between staff and clients are designed so that the program does not so much direct its clients as give them opportunities for self-direction.

STANDARD

Clients are encouraged to formally influence the provider's organization through input into its policies, structure, and operations.

CORE PRACTICES

1. The provider establishes a formal mechanism for clients to provide input into policies, structure, and operations.

OUTCOME

There is evidence that recommendations made by clients related to the provider's operations, policies, and decisions have demonstrable impact on service delivery.

CONSUMER PARTICIPATION IN DECISION MAKING

ADDITIONAL GUIDANCE

1. A consumer advisory board (CAB) or tenant council is set up to represent the concerns and perspectives of the entire constituency of residents. All clients are made aware of the existence and role of the CAB. Representatives are selected through a fair and impartial process.
2. There is a clear definition of the basic functions of the CAB, as described in its bylaws, with respect to:
 - Overall purpose
 - Nature of issues it will address
 - Whether its decision-making is purely advisory or actually authoritative
3. CAB members are referred to skill-building seminars and workshops that can enhance their abilities in self-advocacy, problem solving, and conflict resolution. CAB members can be referred to:
 - Statewide constituencies of consumers living with HIV/AIDS
 - Regional and national workshops and conferences
 - Supportive housing consumer advocacy activities
4. The structure, meeting format, and processes of the CAB are flexible and based on the needs of individual members.
5. The provider identifies multiple venues, in addition to the CAB, to include clients in governance of the program. The provider may ask clients to:
 - Meet with potential employees and participate in hiring decisions
 - Plan special events or activities
 - Participate in program evaluations and provide feedback about specific services or policies
 - Act as spokespersons for the provider and conduct outreach activities
 - Serve on the Board of Directors, if this does not present a conflict of interest

GRIEVANCE PROCEDURES



INTRODUCTION

There may be occasions when clients of HIV/AIDS housing have complaints concerning staff, services, or other issues. Such concerns are usually resolved through informal discussion. However, some problems may remain unresolved. Therefore, it is important that the provider develop conflict resolution strategies and grievance procedures.

STANDARD

Complaints and interpersonal problems are solved as quickly and closely to the source as possible. In situations where a problem persists, a simple and clear grievance procedure is implemented. Clients are encouraged to use the grievance procedure and are guaranteed freedom from recrimination. The grievance procedure is made available to clients.

CORE PRACTICES

1. The provider has a clear, written grievance procedure for addressing unresolved conflicts between clients and staff. The procedure is made available to staff and clients. At intake, clients sign documentation that they have been informed of the procedure.
2. A conflict resolution strategy is used as a first step to resolve grievances informally.
3. In situations where conflict resolution fails, a grievance procedure is implemented when requested by the client. The grievance procedure outlines steps in which clients express concerns that may culminate in some form of hearing with a senior staff member or other body. There is a time frame for responding to grievances.¹²
4. Clients' problems with services or staff can be expressed without concern for punitive consequences.

¹²For more detail about developing Grievance Procedures, please see the Boston AIDS Consortium report, *Consumer Grievance Procedures: A Mechanism for Assuring and Improving Quality of HIV/AIDS Care and Services* (1998)

GRIEVANCE PROCEDURES

5. Grievances are recorded on a standard grievance report form and maintained on file.

OUTCOME

The grievance procedure helps resolve interpersonal conflicts in the housing program. Clients are aware of and feel comfortable with their ability to file a grievance.

ADDITIONAL GUIDANCE

1. Conflict resolution may consist of the following steps:
 - An appointment is made to discuss the problem at a convenient time for both parties.
 - A neutral place to meet is determined.
 - A neutral third party (ideally trained in conflict resolution) facilitates the discussion.
 - Before the discussion, involved parties agree to accept the outcome in good faith.
 - Ground rules for discussion are outlined and include respectful behavior and speaking in turn.
2. A grievance procedure may consist of the following steps:
 - A written grievance is submitted to the program director. The client may request assistance in writing the grievance.
 - The program director and client meet to discuss the grievance.
 - The program director responds to the grievance in writing within five working days of the meeting, summarizing the meeting, and proposing a resolution. The program director provides this document to the client and places a copy in the client's file.
 - If the client is not satisfied with the response, the client submits the grievance to the designated agency representative within ten working days of receiving the response. The agency representative responds to the grievance in writing within thirty working days, summarizing the meeting, and proposing a solution.

3. Clients are permitted to have a support person of their choice accompany them to a meeting regarding a grievance.
4. Agencies designate a specific staff member to make final decisions pertaining to grievances.

DUE PROCESS AND TERMINATION OF SERVICES



INTRODUCTION

The term “due process” refers to the specific series of notices a client must receive prior to termination from services, including rental assistance. A due process must be followed to ensure the protection of clients’ rights. Providers that receive certain forms of funding are mandated to follow such a process. A due process policy will help to preserve a provider’s reputation for fairness with other clients and the wider consumer community.

STANDARD

The provider follows a series of steps, known as a due process, in making a decision to terminate a client from program participation. The due process ensures fairness with respect to time frames and reasonable cause for termination of services.

CORE PRACTICES

1. An due process policy for requesting the termination of a client’s participation in services is in writing and is available to staff and clients.
2. In following due process, the provider includes the following steps and/or procedures in its warnings to clients:
 - In the initial verbal warning, specific concerns are outlined by a senior staff member, and desired changes are specified.
 - In the first written warning, the history of concerns is described chronologically and in detail. Desired changes, to occur within a specific time frame, are outlined.
 - In the second written warning, the client’s failure to correct problems is conveyed. The warning indicates the likelihood that the client will be asked to leave and offers an opportunity for the client to meet with staff to discuss the situation and mutually problem-solve.

DUE PROCESS AND TERMINATION OF SERVICES

- In the final written notice, the client is instructed that he/she is being terminated from services and that a legal eviction may follow. The provider offers assistance in securing an alternative place to live and notifies the client of legal advocacy and representation available.
- All steps of the due process are recorded in writing, and copies are maintained on file. Letters are mailed via certified mail.

OUTCOME

A client's legal right to be treated fairly is protected in situations where the individual may be asked to end participation in services. Clients understand that they will receive warnings, under almost all circumstances, before they are asked to end their participation.

RESIDENT EVICTIONS



INTRODUCTION

HIV/AIDS supportive housing is unique in that it often includes a program and services; however, it does not differ from ordinary tenancies regarding how evictions must be handled. Supportive service providers and landlords are required to follow specific procedures for evicting a client from housing. Neither the service provider nor the landlord has the authority to evict a client from housing; only a judge may legally evict a client. Tenants may sometimes agree to leave voluntarily to avoid a formal eviction process. In cases where a client does not choose to leave, and the provider or landlord wants to pursue an eviction, a legal eviction process must be followed. Providers can work with landlords to facilitate an eviction process which adheres to their due process policy and fair housing law.¹³

STANDARD

State laws and regulations regarding eviction must be followed. The client's rights are not violated, and the provider keeps written documentation regarding any client's eviction process.

CORE PRACTICES

1. The provider/landlord only pursues a client's eviction if it can verify that the client has violated the lease in some way. Examples include:
 - Non-payment of rent
 - Disturbance of the health, safety, or welfare of others
 - Damage to the premises
 - Interference with the management of the premises
 - Repeated violations of the program agreement, where the violations are manifestly related to the program's purpose
2. The provider/landlord does not perform "self-help" evictions, i.e., does not turn off a resident's power or change the locks.

¹³ In some cases, the provider is also the landlord.

RESIDENT EVICTIONS

3. Clients understand why they are being evicted, and a due process is followed prior to evictions.
4. Clients who leave a tenancy voluntarily are asked to sign an agreement to mutually terminate a lease. Clients receive a copy of this document. The provider/landlord understands that the client has a legal right to reverse such a decision despite signing the agreement. A signed copy of the agreement is kept in the client's file.
5. The provider/landlord has legal counsel available to seek an eviction in situations where the internal due process alone does not end a tenancy. The provider/landlord pursues an eviction through local housing courts whenever possible.
6. The provider/landlord can expect an expedited eviction when evidence indicates that residents have:¹⁴
 - Sold illegal drugs on the premises
 - Used illegal drugs on the premises
 - Conducted prostitution on the premises
7. The provider maintains information about emergency resources to which clients can be referred if they are required to leave the housing program. The provider makes every effort to extend support and services to a client who is leaving the provider.

OUTCOME

The provider follows the law with regard to an eviction. Clients' rights are respected.

¹⁴ Under certain circumstances, the provider's ability to follow due process will be impeded. This will occur primarily when the client is conducting or participating in illegal activities. See recommended practice #6.

ADVANCE DIRECTIVES



INTRODUCTION

Advance directives are a set of plans, often prepared with assistance from an attorney, that dictate what is to be done in the event of one's incapacity to make important decisions. They can address everything from medical intervention to child custody issues. Advanced directives allow clients to make proactive decisions concerning the last stage of their lives.

STANDARD

The provider informs clients about the existence, availability, and purpose of advance directives. Advance directives are recommended to all clients, regardless of health status.

CORE PRACTICES

1. The provider has a policy on advance directives that is made available to clients. Program directors and case managers are knowledgeable about available resources and are able to make referrals as appropriate.
2. Clients learn that advanced directives are recommended for all clients regardless of health status.
3. The provider respects clients' choices to postpone the preparation of advanced directives.

OUTCOME

Clients exercise choice and control over how their health care will be provided, who will make decisions on their behalf, and what will happen to them, their family, and their property in the event of their deaths.

ADDITIONAL GUIDANCE

1. Staff refer clients to appropriate resources that are able to clarify each type of directive, including the following:
 - Living Will: A set of directions pertaining to the desired use of medical measures in the event one is incapacitated beyond making such decisions
 - Do Not Resuscitate Order: An order not to use extreme measures for resuscitation
 - Standby Guardianship: An order designating an individual to become guardian of one's dependents
 - Legal Proxy: An order designating an individual to assume legal authority over one's estate
 - Health Care Proxy: An order designating an individual to make one's medical decisions in the event one becomes unable to do so
 - Will: An order that outlines wishes related to one's funeral, burial, and the disbursement of one's estate
2. Whenever possible, the provider urges that clients designate private individuals who are not affiliated with the agency to serve as health care proxies. If the client requests that staff take on this role, the provider may agree as a last resort but should protect staff boundaries by assigning this role to the most senior staff member.
3. The provider is not identified as a legal proxy for clients. This arrangement can create conflicts regarding a client's estate in the event of death.

ADVANCED-STAGE HEALTH CARE AND DEATH PROTOCOLS



INTRODUCTION

Advanced stage health care encompasses the range of services provided to clients during the last months of their lives, and the assistance and support extended to bereaved family members and friends. Providers can, and often will, experience both expected and unexpected deaths of clients. In either situation, the provider has many responsibilities to the client and their loved ones.

STANDARD

The provider has policies in place regarding its provision of advanced-stage health care. The provider makes every effort to support clients' wishes regarding their advanced stage health care. Clients' wishes to die in their homes are accommodated whenever possible. Clients are treated with dignity, respect, and sensitivity.

CORE PRACTICES

1. During the admission process, clients are informed of the ability and limitations of staff to connect clients with advanced stage health care.
2. The provider respects the individual client's choices regarding advanced stage health care. The provider makes plans to access alternative settings should their housing arrangement become untenable. The provider makes every good faith effort to accommodate a client's wish to die at home by evaluating the needs, safety, and support network of the client.
3. The provider makes individual assessments of the safety of clients who experience seriously debilitating illnesses. Staff evaluate such clients' ability to use appliances, such as stoves, safely, ability to remember important information, such as the address where they live, and ability to ask for help in emergencies.

ADVANCED-STAGE HEALTH CARE AND DEATH PROTOCOLS

OUTCOME

Clients direct, to the extent possible, the advanced stage health care they receive. A client's desire to die at home is honored whenever possible.

ADDITIONAL GUIDANCE

1. Caregivers are aware of the family, friends, clergy, and others whom the client would want contacted in the event of their death.
2. Possessions left by a deceased client are collected by the person designated in the will. In absence of a will, the provider warehouses possessions for 90 days.

PROGRAM EVALUATION



INTRODUCTION

Evaluations help program staff to learn about the effectiveness of service delivery, the efficiency of management practices, client satisfaction, and other areas pertinent to the operation of supportive housing.

STANDARD

The provider implements some kind of program evaluation to analyze the effectiveness of its processes and the quality of its outcomes. There is evidence that the provider has integrated findings of evaluations in its operations.

CORE PRACTICES

1. The provider or agency has a mission statement, specific program goals, and quantifiable objectives. Goals and objectives are revisited regularly.

OUTCOME

Clients receive services from an agency that demonstrates a commitment to ongoing quality improvement and that adapts to change in the HIV/AIDS and supportive housing fields.

ADDITIONAL GUIDANCE

1. In planning and conducting a program evaluation, the provider does the following:
 - Forms an evaluation team consisting of internal stakeholders such as clients, staff, and community members
 - Identifies aspects and/or outcomes of the program for the team to evaluate
 - Clarifies expectations
 - Identifies appropriate indicators for issues that will be evaluated
 - Formulates an evaluation plan
 - Designs and pilots data collection instruments and procedures

PROGRAM EVALUATION

- Gathers and organizes data
 - Analyzes data
 - Reports findings to target audiences
 - Incorporates findings and audience feedback into program planning
2. Data collection options for evaluations can include the following:
 - Interviews
 - Focus Groups
 - Surveys
 - Observation
 - Review of materials
 3. Evaluations are structured such that individual staff members are not critiqued and do not experience the process as a form of performance review.

NEEDS ASSESSMENT



INTRODUCTION

The needs assessment evaluates, with accuracy and sensitivity, the client's service related needs. The needs assessment serves as the basis for developing an initial individual service plan and for ensuring the quality of the overall care to be provided. Once the initial needs assessment is complete, a schedule for ongoing reassessments of the client's status is developed and followed.

STANDARD¹⁵

The service provider develops a needs assessment tool to be used consistently with all clients. A client-driven process for implementing needs assessments is in place. Needs assessments are fair and comprehensive and are conducted in a confidential, sensitive, and timely manner. Needs assessments are completed prior to the development, revision, or update of a client's service plan to ensure that needs are identified and addressed.

CORE PRACTICES

1. The needs assessment is conducted within 30 days of a client's admission into the HIV/AIDS housing program.
2. The provider ensures that the initial assessment is updated as the needs of the client change. At a minimum the assessment is updated every six months. Regardless, it is always done prior to the development of a revised service plan. The needs assessment is developed collaboratively, in a face-to-face meeting between the client and the provider. Each needs assessment is dated and signed by the client and the staff.
3. Information requested during the needs assessment includes:
 - Medical history, medical providers, and health status
 - Mental health and emotional status

¹⁵ The service provider must work with the landlord/owner to ensure that the needs assessment and tenant selection are separate activities. These activities may be concurrent only if they are conducted by separate parties and if information from the needs assessment is not introduced during the tenant selection process.

NEEDS ASSESSMENT

- Substance use history and current status¹⁶
- Activities of Daily Living (ADL) needs
- Spiritual/religious needs
- Support system (family, friends, others)
- Legal issues
- Family issues
- Financial resources/insurance status
- Nutritional needs
- Harm reduction practices
- Discharge planning

OUTCOME

Clients receive supportive housing services from a provider who has sufficient current information to fully understand their needs and preferences.

ADDITIONAL GUIDANCE

1. Needs assessments may include information gathered from family members, medical, and mental health providers, and other sources if the client approves contact with such individuals.

¹⁶ For additional information about substance use history and eligibility for housing, please see the Tenant Selection Standard.

INDIVIDUAL SERVICE PLANS AND CASE MANAGEMENT



INTRODUCTION

Individualized Service Plans (ISPs) are written outlines of clients' personal life goals based on priorities identified in their needs assessments. ISPs document the necessary steps for meeting these goals. The model of supportive housing (i.e. the intensity of case management services) will influence the level of staff involvement in developing and implementing service plans.

The goal of case management in HIV housing is to foster an environment where clients increase their independence and improve their decision-making skills. Case management seeks to empower clients to become self-sufficient. A case manager ensures that care is provided in a coordinated way, and in a manner that is culturally and linguistically sensitive.

STANDARD

Clients and providers work together to develop ISPs that are based on the priorities identified in needs assessments and reassessments. ISPs are re-evaluated and updated at least twice a year to incorporate the clients' changing needs and preferences. In addition, value is placed on the need for clients to be able to make personal choices about the course of their lives

Case management services encompass much of this work: assessing clients' needs, developing ISPs, consistently monitoring clients' progress, coordinating service delivery, and specifically, coordinating case management services when more than one service provider is involved in a client's care. If the provider is unable to offer comprehensive case management services, staff assist clients with appropriate referrals to outside agencies.

INDIVIDUAL SERVICE PLANS AND CASE MANAGEMENT

CORE PRACTICES

1. In coordination with the needs assessment, the ISP is completed within 30 days of acceptance into the HIV/AIDS housing program.
2. At a minimum, the ISP is reviewed and updated every six months.
3. The ISP is developed collaboratively in a face-to-face meeting between the client and the provider. Each ISP is dated and signed by the client and staff.
4. At a minimum, the ISP includes:
 - The client's plan for long-term residential stability
 - The client's area of focus related to HIV/AIDS, substance use, mental health needs, and other needs
 - Short and long-term goals and measurable objectives for addressing each area of focus.
 - Action steps required to address each objective, including necessary resources and services.
 - Projected time frames for all action steps
5. All attempts to implement the ISP are documented clearly and on a regular basis. The documentation includes summary notes describing actions to obtain services, frequency of contacts, and plans for follow-up, if indicated.
6. All clients participate in some form of case management. Case management models will vary depending on the housing program and the client. In some cases, a client might receive case management services daily, in other circumstances, a client might receive services twice a year.
7. Case managers locate, provide supported referrals to, and monitor (with the necessary informed consent of the client) all necessary medical, social, mental health, and support services in collaboration with the client.

OUTCOME

Clients have ISPs that identify specific services and goals that are needed and desired. Clients have access to case management and other types of care that help them promote and maintain their health, well being, and independence.

ADDITIONAL GUIDANCE

1. The ISP helps clarify the needs of the client in a non-judgmental format.

CLIENT HEALTH CARE



INTRODUCTION

Ensuring that all clients are connected to health care is an important goal for HIV/AIDS housing providers. Depending on the capacity and training of staff, health care may be provided to the client by the provider's agency or by outside medical professionals.

STANDARD

The housing provider ensures that all clients have secured a primary health care provider. Clients' health needs are addressed in their ISPs. The provider helps to ensure that clients receive a continuum of health-related services.

CORE PRACTICES

1. ISPs address clients' health care needs in a timely manner. The provider ensures that appropriate referrals are offered and/or made.
2. The provider works to ensure, in a timely fashion, that clients have access to a continuum of health care services on an as-needed basis that includes:
 - Primary care
 - HIV specialty care (from an infectious disease specialist)
 - Dental care
 - Home-care
 - Alternative forms of health care
3. The provider promotes preventive health care by encouraging clients to make and meet scheduled appointments and remaining aware of changes in clients' health status.

CLIENT HEALTH CARE

OUTCOME

Clients are aware of the continuum of health care services available to them. The provider supports clients in maintaining their health to the greatest extent possible.

ADDITIONAL GUIDANCE

1. The provider is knowledgeable of any medical conditions that may adversely affect the health or safety of clients.
2. Training related to HIV/AIDS, Hepatitis C, diabetes, substance use, and other related health issues is provided by trained health care professionals on a regular basis to staff and clients.

MENTAL HEALTH CARE



INTRODUCTION

Mental health care addresses pre-existing and chronic mental illnesses as well as mental health issues associated with HIV/AIDS. Clients may access mental health care through a variety of organizations including AIDS service organizations, hospitals, community mental health centers, ambulatory care centers, and community-based organizations.

STANDARD

When appropriate, the provider refers clients to mental health care services that are available in the community. Clients' mental health needs are addressed in their ISPs. Staff are up-to-date on mental health issues that may affect clients. All mental health diagnoses and treatment plans are made by a licensed mental health professional.

CORE PRACTICES

1. ISPs address clients' specific mental health needs in a timely manner. The provider ensures that appropriate referrals are offered and/or made to mental health services.
2. The provider has a policy and procedure for responding to mental health crises. Staff are trained to identify such emergencies and make appropriate referrals.
3. The provider arranges to have mental health professionals conduct regular trainings with staff on current mental health issues.

OUTCOME

Clients have their mental health needs identified, diagnosed, and treated. Mental health issues, including those that are associated with HIV/AIDS or substance use, are recognized and understood by staff. The safety and well-being of clients with mental health issues are maintained.

MENTAL HEALTH CARE

ADDITIONAL GUIDANCE

1. Mental health care is provided in a manner which is accessible to residents from a variety of ethnic and linguistic backgrounds.

NUTRITIONAL CARE



INTRODUCTION

Adequate nutrition and good dietary habits contribute to maintaining and improving health. A program of nutritional care can be a useful complement to the staple services that are provided.

STANDARD

The provider develops written protocols related to nutritional care. Staff help to ensure that clients' nutritional needs and special dietary requirements are met through appropriate referrals.

CORE PRACTICES

1. The provider has written protocols to ensure that clients are educated about and have access to appropriate and nutritious food.
2. The provider assists clients in accessing home-delivered meal services and food pantries on an as-needed basis.

OUTCOME

Clients have information and access to the resources needed to follow a nutritionally appropriate diet that helps maintain and/or improve their health.

ADDITIONAL GUIDANCE

1. The provider has access to a licensed nutritionist who periodically works with staff and clients to address nutritional needs. These needs are incorporated into clients' ISPs.
2. The nutritionist visits with clients who have nutrition related needs on a regular basis. The nutritionist works with the client's health care provider, when consent is given.

DRUG AND ALCOHOL USE AND RELAPSE PREVENTION



INTRODUCTION

Drug and alcohol use in HIV/AIDS housing is often a difficult and controversial issue for providers. Many clients have past or current histories of substance use that may complicate their ability to live independently and manage personal issues. The goal for providers is to respond appropriately and with sensitivity to clients' needs. In addition, providers are mindful of the fact that current illegal drug use is frequently considered a lease violation and may jeopardize a client's housing, especially in the private housing market.

STANDARD

The provider has a written policy regarding the use of illegal drugs and misuse of legal drugs. The provider has protocols for identifying clients at risk of relapse, determining if relapse has occurred, and negotiating admission to detoxification and after-care programs. Providers who specifically target clients with substance use histories employ staff who are knowledgeable regarding substance use and recovery issues as they relate to HIV disease.

CORE PRACTICES

1. The provider develops a model (see below for some examples) and a policy regarding substance use and relapse.
2. There is a written policy regarding substance use relapse that is available to staff and clients. The policy includes protocols for negotiating admission to detoxification and after-care programs.
3. Education, counseling, and other forms of addiction treatment are made available to clients through referrals to therapists and drug treatment providers.
4. Staff are trained in how to respond to the consumption of illegal drugs and relapse.

DRUG AND ALCOHOL USE AND RELAPSE PREVENTION

OUTCOME

Clients understand the substance use policy and can use addiction services as needed. Clients are able to obtain support and assistance from staff in their efforts to regain and maintain their recovery.

ADDITIONAL GUIDANCE

1. The relapse policy is based on a non-shame-based approach which supports the client who has suffered a relapse.
2. The following are examples of three different models that can be used in HIV/AIDS housing programs. Regardless of the model a provider chooses to follow, the provider must operate within the confines of housing law.

The Sober Model:

Description: Providers that follow the “sober model” encourage total sobriety among their clients. One uniform standard for behavior is applied to all.

- a. The provider’s policies related to recovery, relapse, and relapse prevention are made known to the client before admission. The consequences of active substance use are made clear to the client.
- b. Clients with histories of substance use are required to participate in relapse prevention activities.
- c. Relapse prevention activities may take the form of meetings or groups such as:
 - Alcoholics Anonymous (AA)
 - Narcotics Anonymous (NA)
 - Peer-led, participatory relapse prevention groups
 - One-to-one relapse prevention counseling
 - Professionally facilitated relapse prevention groups
 - HIV and substance use support
- d. Education, counseling, and other forms of addiction treatment are made available to clients through therapists and drug treatment providers.
- e. If a client relapses, the provider has a clear policy for responding to the

relapse that can include:

- admission to a treatment program such as detoxification or outpatient counseling
- referral to addiction treatment providers
- development of an individual contract between the provider and client stating the consequences of future relapses

The Multi-Strategy Model

Description: This model combines aspects of the sober model with what is known as the harm reduction model. It allows providers to encourage clients to remain sober and drug-free while offering harm reduction to clients who relapse. This model is based on the belief that recovery is an individual process that requires individually-tailored approaches to relapse.

- a. The provider's policies related to recovery, relapse, and relapse prevention are made known to the client before admission.
- b. Activities promoting relapse prevention are available.
- c. Strategies for addressing relapse are drawn from the sober model and the harm reduction model based on the current needs and status of the individual.

The Harm Reduction Model:

Description: The theory of harm reduction emerges out of community-based, public health interventions that support drug users and their communities in reducing drug-related harm. It seeks to reduce the amount of risk in drug-using behaviors and increase the health of the person living with HIV/AIDS, their caregivers, and the society as a whole. The hierarchy of harm reduction with the injection drug user begins with a focus on safer drug use techniques (i.e. safer injection techniques, safer location choice), cessation of injection, and ultimately, cessation of drug use. Incorporated within this is attention to health problems and the prevention of health problems before they occur. The harm reduction model can also be applied to other addictions and health practices.

- a. For clients with addictions or histories of addiction, the provider clearly defines the consequences of drug use and its associated behavior.

DRUG AND ALCOHOL USE AND RELAPSE PREVENTION

- b. ISPs for clients with active addictions are tailored to address the current needs and reality of the individual (i.e., novice or veteran user). Such an ISP can include the following strategies:
 - Creating a climate of trust through a consistent approach to dealing with the drug use
 - Improving quality of life (e.g., better nutrition)
 - Encouraging the client to seek support in the community
 - Encouraging health care and service providers to work together
- c. ISPs for clients in recovery can include the following strategies:
 - Providing psychosocial support
 - Reinforcing clients' decisions to stop their chemical dependency
 - Encouraging clients to strengthen ties to their support network
 - Discussing potential relapse situations and ways to deal with them
 - Encouraging self-awareness through addiction education

All staff affiliated with the provider promote a nonjudgmental environment for all clients, regardless of their histories.