2017 HIV Community Services Provider Manual

Implementing HIV Community Service Programs in Washington State

**Office of Infectious Disease
Washington State Department of Health**

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Contents

How to Use this Manual

This manual provides an overview of Washington's HIV Community Services (HCS) programs, articulates applicable standards of care, and describes minimum requirements around policy, process, and reporting expected of providers receiving DOH funding for serving persons living with HIV (PLWH) or persons at high risk (PAHR). The requirements outlined reflect a minimum standard of care that is essential to meet the needs of PLWH and PAHR. Adherence to these policies and standards ensures quality services that are consistent across agencies and our service continuum. The establishment of such standards allows DOH a set of measures by which to evaluate subrecipient performance and intervention effectiveness.

The manual includes the following sections:
1. **Introduction:** Helps the reader to know how to use the manual. It provides an overview of services offered in Washington.
2. **Overview:** Provides an overview of the HIV service delivery system in Washington.
3. **Universal Standards:** Presents the minimum requirements and policies that DOH expects programs to meet for funded case management, core medical, and support programs.
4. **Fiscal Monitoring:** Outlines invoicing requirements, payer of last resort, and program income.
5. **PLWH Core Medical and Support Services Standards:** Includes guidelines and requirements for PLWH services. DOH subrecipients providing any of these services must refer to this section to ensure compliance with program requirements.
6. **Program Monitoring:** Describes how DOH monitors the quality and quantity of the services provided.
7. **Quality Improvement:** Describes quality improvement activities intended to improve performance through ongoing quality monitoring, evaluation, and improvement processes.
8. **Data:** DOH uses Washington CAREWare System for collecting and reporting on HCS. This section describes how providers can use CAREWare to gather and report client-level and service data.

Introduction

Washington State launched the *End AIDS Washington*[1] campaign on December 1, 2014, World AIDS Day, in support of Governor Jay Inslee's public commitment to ending the HIV epidemic in our state. The campaign calls on state and local governments, community-based organizations, healthcare providers, and others to work together to increase community viral suppression, reduce health disparities, improve health outcomes, and reduce new HIV infections by 50 percent by the year 2020.

Over the next three years, the Department of Health (DOH) will work with partners to accomplish the *End AIDS Washington* goal by focusing investments on four main strategies:

- **Getting people insured:** Health insurance coverage connects people to healthcare. With health insurance, people are tested for HIV, get pre-exposure prophylaxis (PrEP), get treatment, and receive many other services important to staying healthy.
- **Getting people tested:** Knowing one's HIV status helps people make informed decisions about their own health and the health of their partners. After getting an HIV test, persons at high-risk for HIV infection (PAHR) can link to PrEP, and persons living with HIV (PLWH) can link to medical care and treatment.
- **Getting at-risk people on HIV PrEP:** PrEP helps PAHR reduce their risk for HIV infection. By using PrEP, people take an active role in keeping themselves HIV negative.
- **Getting HIV-positive people on treatment:** Treatment helps PLWH stay healthy. Treatment also helps PLWH reduce the chances they pass HIV to others.

HIV Prevention, Care and Treatment System

End AIDS Washington guides the overall focus of the HIV prevention, care, and treatment system (Illustration 1). This system is composed of three domains:

1. **HIV Community Services (HCS)** (e.g. population-based services, outreach, HIV testing in nonclinical settings, healthcare navigation and coordination, case management, support services, re-engagement in HCS, linkages to Public Health and Clinical Services)
2. **Public Health Services** (e.g. surveillance, disease investigation, HIV/STD partner services, re-engagement in HIV care, linkages to HCS and Clinical Services)
3. **HIV Clinical Services** (e.g. medical care and treatment, Early Intervention Program and other medication assistance programs, health insurance, re-engagement in HIV care, linkages to Public Health and HCS.

HCS include activities that connect PAHR and PLWH to antiretroviral medications (ARVs) and support services. HCS complement Public Health Services and Clinical Care Services by supporting customers' ongoing engagement and retention in healthcare.

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[1] http://endaidswashington.org/

Illustration 1: The Three Domains: HIV Prevention, Care, and Treatment System
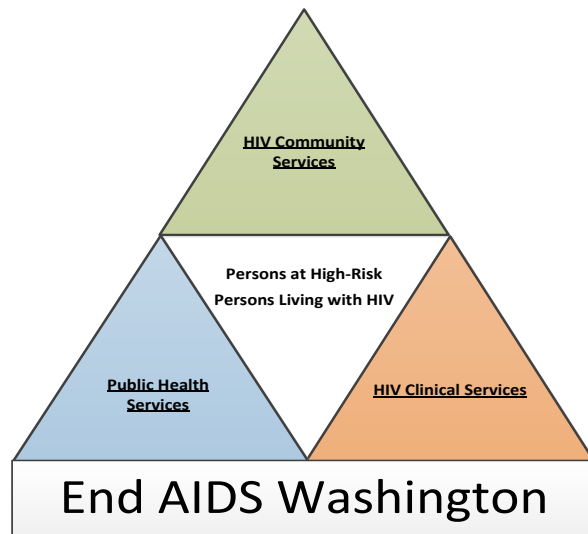
Antiretroviral Focus

The HCS model focuses attention on both Pre-Exposure Prophylaxis (PrEP) and HIV treatment. While PrEP and HIV treatment serve different groups of people, with different aims, individuals who use PrEP and HIV treatment often have similar needs, require similar services, and face common obstacles. Both PrEP and HIV treatment are highly connected to the healthcare system and rely on HCS providers for ongoing support. We use a common indicator to determine success for both PrEP and HIV treatment – appropriate use of ARVs. Illustration 2 – Common ARV Pathway for PrEP, details the common pathway for successful ARV use for PrEP and HIV treatment.

Illustration 2: Common ARV Pathway for PrEP and HIV Treatment
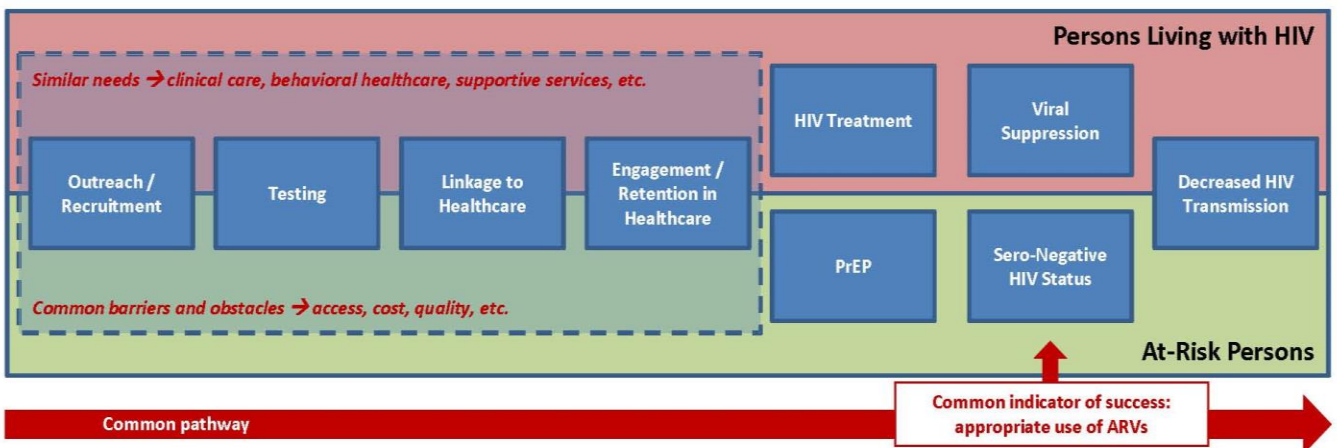
In recent years, researchers have found that ARV use can significantly reduce HIV transmission from an infected person to his or her uninfected partner(s). Two primary strategies have emerged from this research: (1) early and sustained treatment for PLWH, also known as treatment-as-prevention, and (2) PrEP for PAHR.

Overview

Office of Infectious Diseases

The Office of Infectious Disease (OID) administers HIV Community Service (HCS) funds for Washington State. OID is in the Division of Disease Control and Health Statistics. The purpose of HCS funding is to reduce the transmission and medical consequences of HIV by assuring that persons living with HIV (PLWH) or persons at high risk (PAHR) in Washington have access to health care and supportive services. OID is committed to developing and maintaining an HIV continuum of care that meets goals outlined in the National HIV AIDS Strategy (NHAS) and End AIDS Washington initiative.

Guiding Principles

OID oversees the implementation of HCS to make sure:

- An evidence-based care system exists that serves PLWH and PAHR within a comprehensive continuum of primary care and supportive services
- Care services facilitate access to existing and emerging HIV/AIDS treatments
- Funding for HIV care services for women and children and racial or ethnic minorities are, at a minimum, proportionate to HIV/AIDS prevalence in the state
- Washington State addresses the needs of emerging populations by funding outreach efforts that encourage early participation in HIV medical care
- Providers document the impact of services on improving access to quality care and treatment for PLWH and PAHR

OID utilizes a systematic process for planning, designing, measuring, assessing, and improving performance, which includes:

- Collecting and recording data and observations related to the delivery of services
- Using assessment procedures to determine efficacy and appropriateness of interventions, how well providers deliver services, and opportunities for improvement.
- Focusing on improving quality by implementing data driven recommendations and encouraging participatory problem solving
- Promoting communication, dialogue, and exchange of information across the department and throughout the community about findings, analyses, conclusions, recommendations, actions, and evaluations pertaining to performance improvement
- Striving to establish collaborative relationships with diverse community providers for collectively promoting the general health and welfare of the community served

Early Intervention Program

OID's HIV Client Services program assures that PLWH in Washington State have access to essential health services. HIV Client Services' Early Intervention Program (EIP) directly pays for prescription medication coverage, medical care, insurance premium payment assistance, insurance co-pays, dental services, and mental health services. HIV Client Service's HCS Program contracts with community partners to provide case management and other support services.

The Early Intervention Program provides services to help eligible persons with HIV get the health care they need to improve or maintain their health. To be eligible a person must:
- Be HIV positive
- Live in Washington State
- Have family income at or below 400% Federal Poverty Level (FPL). Family includes legally married spouse or domestic partner and dependent children age 18 and younger

EIP provides services for all of Washington State. Covered EIP services include:
1. Prescription Medication Coverage (AIDS Drug Assistance Program (ADAP))
   a. EIP maintains a formulary to treat HIV and many related conditions
   b. EIP pays insurance co-pay costs for medications on the formulary
   c. EIP pays for HIV medications on the ADAP formulary at full cost for PLWH who do not have insurance
   d. Client must use an EIP contracted pharmacy

2. Medical Care
   a. EIP pays for HIV-related office visits and lab tests that are on the list of Covered Medical Services
   b. To receive assistance, eligible clients must go to an EIP contracted medical provider

3. Insurance Premium Payment Assistance
   a. EIP assists clients with medical insurance and can pay the premiums for some plans
   b. Clients enroll by submitting an application to EIP. EIP works directly with its Insurance Benefit Manager to enroll clients into premium assistance
   c. EIP pays for the following plans:
      i) Medicare Part D and Medicare Advantage (MAPD) plans
      ii) Healthcare for Workers with Disabilities (HWD)
      iii) Employer-sponsored insurance
      iv) Qualified Health Plans in the Exchange
      v) Individual Plans

4. Insurance Co-Pay, Coinsurance, and Deductibles
   a. EIP assists eligible clients with medical insurance co-pays, coinsurance, and deductibles
   b. To receive co-pay, coinsurance, and deductible assistance, clients must be enrolled in EIP

    c. EIP pays the co-pays and coinsurance for HIV-related medical visits and tests on the list of Covered Medical Services

    d. To receive assistance, eligible clients must go to an EIP contracted medical provider

5. Dental Services
    a. EIP pays for limited dental services on its Covered Dental Services list
    b. To receive coverage, eligible clients must go to an EIP contracted provider for EIP covered dental services
    c. The maximum coverage is $3,000 per calendar year

6. Mental Health Services
    a. EIP pays for mental health services
    b. To receive coverage, eligible clients must go to an EIP contracted provider for EIP covered mental health services

Link to EIP Services:
http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP

HIV Community Services

OID has contracts with community providers to provide HCS. These services include outreach, case management, substance abuse treatment services, mental health services, medical transportation, food bank or home-delivered meals, psychosocial support, linguistic services, housing, and early intervention services (EIS). OID abides by the service definitions of Health Services and Resources Administration (HRSA), the federal administrative provider of the Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White Program).

HIV Planning System

Participation in Washington State's HIV Planning Process

The vision of the HIV Planning System is to end the HIV epidemic in Washington State. Collectively we will accomplish this by preventing new HIV infections and by keeping people with HIV healthy. The planning system looks at how HIV affects populations across the state, the factors influencing people's HIV risk and the structures that affect successful HIV efforts. The components of the planning system recommend the most successful HIV prevention, care and treatment strategies. DOH designed Stakeholder Villages and Special Emphasis Workgroups specifically to amplify the voices of individuals and communities experiencing HIV related disparities.

Planning System components

Contracted Providers have unique connections to communities and connecting communities to the planning system is integral to a successful HIV service delivery system. DOH is responsible for implementation of the HIV Planning System. Contracted Providers are responsible to work directly with DOH to implement and recruit participants for Villages and SEW that in their service provision area or target population.

HIV Stakeholder Villages (Villages) have no formal membership and serve the dual purpose of educating a broad range of stakeholders on the current and proposed HIV interventions and strategies receiving input from stakeholders to enhance HIV service delivery. Villages meet in person or via web interface in town hall style meetings held within various communities in Washington State in coordination with local service delivery providers.

HIV Special Emphasis Workgroups (SEW) are informal, ad-hoc, and advisory bodies that DOH convenes to identify specific and effective implementation strategies that add operational value to prevention, care, and treatment continuum activities.

The HIV Planning Steering Group is a 21 member, formal, standing, and advisory committee. Membership includes consumers, as well as professionals with both HIV Care and Prevention experience and expertise. Membership is application based and awarded through a review committee made up of current HPSG members.

Participation in End AIDS Washington Initiative

The End AIDS Washington Initiative is a collaboration of community-based organizations, government providers and education and research institutions working together to reduce the rate of new HIV infections in Washington by 50% by 2020. Any one government provider or CBO does not own the End
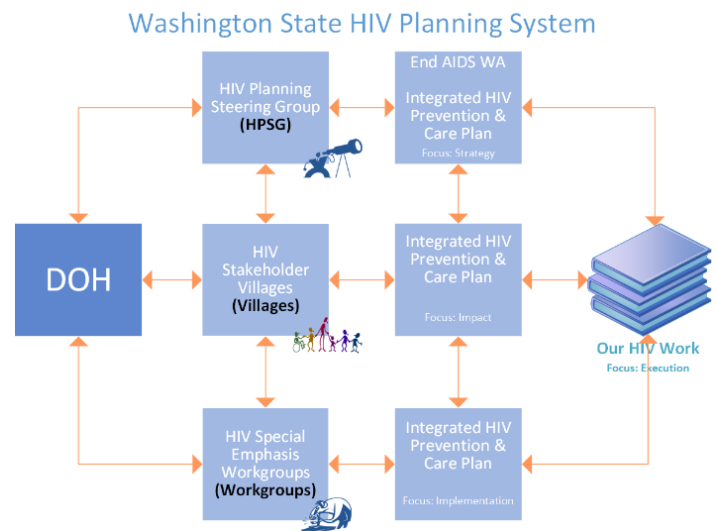
AIDS Washington initiative and the forthcoming implementation plan. End AIDS Washington is a community-owned effort, and will only be successful if all stakeholders—communities, government, the health care system, and people most affected by HIV—are fully engaged in its implementation efforts and empowered to make decisions and set priorities.

Participation in End AIDS Washington Statewide Media Campaign

The End AIDS Washington Statewide Media Campaign effort aims to promote the priorities laid out in the EAW Initiative around the state in various ways. Funded providers will ensure the participation of at least one staff member funded through PAHR Services in End AIDS Washington Campaign related activities including, but not limited to, the End AIDS Washington Champions program. Funded providers will, whenever possible, utilize End AIDS Washington messaging and branding on educational and outreach materials.

Terminology

This manual contains terminology and acronyms that are specific to the HCS program.

AIDS Drug Assistance Program (ADAP) is a state and territory-administered program authorized under Part B that provides FDA-approved medications to low-income people living with HIV who have limited or no health coverage from private insurance, Medicaid, or Medicare. Washington also uses ADAP funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. Washington calls its ADAP the Early Intervention Program, or EIP.

Centers for Disease Control and Prevention (CDC) are the federal provider that administers prevention funding for many diseases including HIV, sexually transmitted disease, and hepatitis.

Clients are persons living with HIV or at high risk for acquiring HIV who access HCS through a funded provider.

Consumers are persons who are at high risk for HIV or who are living with HIV who engage in some aspect of the prevention, care or treatment continuum. Providers and policy makers often use "Clients" and "Consumers" interchangeably, although the latter may be reserved more commonly to refer to PLWH or PAHR outside the reference point of a particular subrecipient or program.

Department of Health and Human Services (HHS or DHHS) is the federal provider that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

Health Resources and Services Administration (HRSA) is an operating division of the DHHS that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

HIV/AIDS Bureau (HAB) is the bureau within HRSA that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

Housing Opportunities for Persons with AIDS (HOPWA) is a federal program dedicated to the housing needs of people living with HIV/AIDS. The U.S. Department of Housing and Urban Development administers HOPWA.

Department of Commerce is the state provider who administers Washington's HOPWA funds.

HCS providers are providers across the State of Washington (and one in Oregon) that provide direct HCS to Washingtonians living with HIV. DOH contracts with HIV Community providers (subrecipients) to make these services available.

Washington State Department of Health (DOH) is the recipient that receives Ryan White Part B funding to provide EIP, case management and support services.

Ryan White Part C providers are clinics that receive direct funding from HRSA to provide medical care.

OVERVIEW – Terminology

Ryan White Part A providers are providers that receive funding from a Ryan White Part A recipient. In Washington, the Ryan White Part A recipients are Public Health Seattle & King County and Multnomah County Health Department. Part A refers to assistance provided under Ryan White to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) most severely impacted by the HIV epidemic. In Washington and Oregon, Part A's are TGAs.

Ryan White HIV/AIDS Treatment Extension Act of 2009 is the largest federal program focused exclusively on HIV care. Congress first enacted the legislation in 1990 as the Ryan White Care (Comprehensive AIDS Resource Emergency (CARE)) Act. Congress has reauthorized the CARE Act four times: in 1996, 2000, 2006, and 2009.

Universal Standards

Universal Standards are the minimum requirements that the Washington State Department of Health (DOH) expects programs to meet when providing HCS funded by DOH. The Universal Standards apply to all funded core medical and support programs and providers. Universal Standards ensure that providers have policies and procedures in place that:

- Establish and Reassess Client Eligibility
- Guarantee Client Confidentiality
- Define Client Rights and Responsibilities
- Outline a process to address Client Grievances
- Ensure the provision of culturally and linguistically appropriate services
- Maximize the Accessibility of services
- Promote the hiring and adequate training of qualified personnel

Providers must have policies and procedures that address the Universal Standards.

The format for Standards Tables is as follows:

Standard	Criteria	Documentation
Minimum requirement that DOH expects programs to meet when providing services.	Specific activities required to meet the standard.	Appropriate documentation required.

Eligibility

Providers must establish client eligibility policies that comply with state and federal regulations. These include screening of clients to determine eligibility for services within 30-days of intake. Providers must have documentation of eligibility in clients' records. For most services, these include proof of HIV status, residence, income, and health coverage status. Exceptions include proof of HIV status for EIS services.

Eligibility Documents

To establish eligibility, providers must document and verify the following information within 30 days of Intake:

- HIV or AIDS diagnosis (Exception includes EIS Services)
- Washington State Residency every 6 months unless otherwise specified.
- Income of client and all applicable household members every 6 months unless otherwise specified.
- Health Coverage Status every 6 months unless otherwise specified.

Eligibility Requirement	Examples of Acceptable Documentation
HIV or AIDS Diagnosis	- Positive ELISA with confirming Western Blot test results - RNA-PCR or Branched DNA test showing detectable viral load of HIV virus - Original lab report indicating HIV positive status (e.g. lab report, med list) - Letter, with signature from MD or ARNP, stating client is HIV positive
Washington State Residency	- Unexpired Washington state driver license or Tribal ID - Unexpired Washington state ID - Washington state voter registration card - Utility bill (cell phone bills not accepted) - Lease, rental, mortgage, or moorage agreement/document - Homeless Client Statement - Award letter from SSI or SSDI with clients address on it - ACES printout (client must be actively receiving services) In certain instances, a client may be unable to produce one of the preferred documentation of Washington residency due to homelessness, undocumented status, or other barriers. In such instances, acceptable forms of documentation are: - A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant - A signed letter from a case manager, or other professional explaining why the client's claim of Washington residency is supportable - It is not necessary to be a U.S. citizen to receive HCS. Applicants do not have to document citizenship or immigration status to be eligible for services.

Income of client and all applicable family members	- Check/pay Stub (must show name, pay period, and gross income received) - Unemployment stub - Monthly benefit statement - Annual benefit statement Employer W-2 - Bank Statements showing direct deposit amounts of SSI or SSDI income - Profit & loss statement - Copy of SSI or SSDI statement - Self-Employment Income Statement (in conjunction with a bank statement) No Income Statement
Health Coverage Status	- Medical or dental insurance card - Medicare/Medicaid Statement

Reassessment of Eligibility

The table above lists examples of documentation that agencies can use to reassess eligibility. In addition to the examples listed in the table, providers may use the EIP Recertification letter as proof of reassessment of eligibility.

Standards

Eligibility

Purpose: Providers of HCS will ensure services are available to all eligible clients. With the exception of Early Intervention Services, eligibility criteria for PLWH programs include written verification of HIV positive serostatus.

Standard	Criteria	Documentation
Services are available to eligible clients.	Providers must periodically review eligibility guidelines to ensure that they are consistent with their contracts.	HCS provider maintains record of individuals that refused services with: - Reasons for refusal specified - Complaints from client - Complaint review - Decision reached
	Providers must actively inform clients on how to access services.	HCS provider has a file documenting provider activities for the promotion of HIV services to persons living with HIV, including copies of HIV program materials promoting services and explaining eligibility requirements.
Service providers will verify and document that individuals receiving services meet income level guidelines. To receive HCS in Washington, PLWH must be at or below the FPL	HCS provider will collect information on household income within 30 days of intake and at minimum every 6 months unless otherwise specified.	HCS provider has documentation of client household income in client file.

used by Early Intervention Program. Washington State exempts case management from this requirement.		
Service providers will verify and document those individuals receiving services are residents of Washington State.	HCS provider will collect verification of Washington residency within 30 days of intake and at minimum every 6 months unless otherwise specified.	HCS provider has documentation of Washington State residency in client file.
Service providers will verify and document that individuals receiving PLWH services are HIV positive.	Service providers will collect verification of HIV positive serostatus.	HCS provider has required documentation of HIV status in client file.
Service providers will verify and document clients' Health Coverage Status.	Service providers will collect verification of Health Coverage Status.	HCS provider has documentation of Health Coverage Status in client file.
HCS provider will re-certify client eligibility once every six months unless otherwise specified.	HCS Provider will reassess eligibility every 6 months unless otherwise specified.	HCS provider documents all updates to client's eligibility in client file.

Confidentiality

A confidentiality policy protects clients' personal and medical information such as HIV status, behavioral risk factors, and use of services. Providers must have a confidentiality policy that aligns with state and federal laws (WAC 182-539-0300/0350). The confidentiality policy must include consent for release of information (ROI), duty to warn, and storage of client records.

Release of Information

Providers must develop an ROI that describes the circumstances under which a subrecipient can release client information. ROIs must contain an expiration date or an expiration event that relates to the patient or the purpose of the disclosure. The ROI must in in accordance with RWC70.02.030 (Patient Authorization for Disclosure) and WAC182-539-0300 (Case Management for Persons Living with HIV/AIDS). If the Health Insurance Portability and Accountability Act (HIPAA) are applicable, the ROI must be HIPAA-compliant. The ROI must include:

-   Name and date of birth of client/patient whose information is being shared
-   Name of subrecipient or individual with whom information can be shared
-   Types of information to be shared
-   Client signature

Duty to Warn

As part of the confidentiality policy, all agencies must include a duty to warn statement that describes the circumstances under which a subrecipient can release client information without client consent. Duty to warn refers to the responsibility of a case manager to breach confidentiality if a client or other identifiable person is in clear or imminent danger. In situations where there is clear evidence of danger to the client or other persons, the case manager must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm. However, per RCW 71.05.120, if the case manager has reasonable suspicion of the threat, duty to warn protects them from prosecution.

Security of Client Files

To prevent unauthorized persons from accessing confidential information, case managers must secure physical and electronic client files in a manner that meets minimum HIPAA Standards. Security of client files and records must be part of the subrecipient's confidentiality policy. If a subrecipient transports client files outside their subrecipient, they must be:

-   Transported files must be in a locked container and never left unattended
-   Electronic media must be de-identified or encrypted before leaving an subrecipient
-   Provider must retain client files for 6-years after client is deceased or file is inactive

Standards

Confidentiality

Purpose: Confidentiality assures protection of HIV status, behavioral risk factors, or use of services.

Standard	Criteria	Documentation
HCS providers will protect confidentiality in accordance with state and federal laws.	HCS provider will have a client confidentiality policy that is in accordance with state and federal laws that includes: · Staff confidentiality agreement · Training of staff and volunteers · Data release · Policy on storing client information · Confidentiality of data sent or received by mail, fax, telephone, voicemail, or email · Maintaining confidentiality and security when information is taken out of the office · Penalties for violating the policy · Procedures for investigating breaches of confidentiality	HCS provider's confidentiality policy is available for inspection and includes all of the required criteria. HCS provider posts their confidentiality policy in an area(s) readily visible to clients. The confidentiality policy is available to clients and the HCS provider will collect proof of this via Client initials or signature attesting to the receipt and comprehension of said policy.
A Client Release of Information Form must exist describing under what circumstances the provider can release client information.	An up-to-date Release of Information Form exists for each specific request for information · Each request is signed and dated by the client · Name of provider with whom information will be shared · Information to be shared · Duration of the release	HCS provider has a signed Release of Information in each client record that includes all the required elements. ROI articulates parameters of information sharing with funder(s) for the purpose of compliance audits.
All staff and volunteers will sign a statement agreeing to the subrecipient's confidentiality policy.	Employees and volunteers, with access to client records, must sign a Confidentiality Agreement.	HCS provider has a signed staff Confidentiality Agreement for each staff and volunteer.
Provider must have a policy on storing hard copies as well as electronically stored client information.	HCS Provider has a policy on storing client information.	Provider's information storage policy is available for inspection.
	Files are stored in locked file or cabinet with access limited to appropriate personnel.	Provider stores records in locked file, cabinet, or room.
	Electronic files are password protected with access limited to appropriate personnel.	Electronic files are password protected with access limited.
Service providers must have a policy for retaining client records, as well as for destroying records that pass the retention date.	Records are stored and accessible for a period of six years after the closing date.	HCS provider has a record retention policy.
	After the sixth year, providers must destroy records in a way that will maintain confidentiality.	

Client's Rights and Responsibilities

Active participation in one's health care and sharing in health care decisions maximizes the quality of care and quality of life for people living with HIV/AIDS. Providers can facilitate this by ensuring that clients are aware of and understand their rights and responsibilities. Agencies must have a client rights and responsibilities policy that ensures:

- DOH funded HCS services are accessible to clients
- Services are available regardless of client ability to pay
- Nondiscrimination
- Clients have access to their files
- Freedom of choice of provider
- Consumer involvement in the design and evaluation of HCS services

Service Accessibility

HCS services funded by local dollars or Title XIX Targeted HIV Case Management must be accessible to all clients who meet eligibility requirements. Agencies must provide services in a setting accessible to low-income individuals with HIV. Agencies must comply with the Americans with Disabilities Act (ADA) (https://www.ada.gov/) requirements. Agencies must provide services to eligible clients regardless of the client's ability to pay for the service and the client's current or past health condition.

Agencies must document how they promote HIV services. Documentation must include copies of HIV program materials that promote services and explain program eligibility requirements. In addition, according to the National Standards on Culturally and Linguistically Appropriate Services (CLAS), agencies must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group(s) represented in the service area.

Service Availability

Agencies must provide services to eligible clients regardless of the client's ability to pay for the service and the client's current or past health condition. Agencies must have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services. Agencies must maintain files of eligible individuals refused services with reasons for refusal specified. Subrecipient files must include formal complaints from clients, with documentation of complaint review and decision reached.

Nondiscrimination

Agencies provide services to all qualified individuals without discrimination on any basis prohibited by law. This includes HIV infection, race, ethnicity, creed, color, age, sex, gender, gender identity or expression, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap, substance abuse, immigrant status, political affiliations or belief, ex-offender status, unfavorable military discharge, membership in an activist organization

Access to Files

Agencies must have and provide clients a policy for record/file access that is at a minimum in accordance with RCW 70.02.080 and RCW 70.02.090. DOH expects subrecipients adopt a low barrier process for accessing files.

Freedom of Choice of Providers

Agencies must ensure Clients understand their right to choose their HCS provider.

Agencies may refuse to serve a client based on reasonable factors, such as insufficient capacity, or inability to meet the needs of a client in a safe and timely manner. DOH expects subrecipients to document any refusal to serve a client.

Client Input and Feedback

Agencies must incorporate client input and feedback into the design and evaluation of case management services funded by local dollars and Title XIX HIV Case Management. Agencies can accomplish this through:

- Consumer advisory boards
- Consumer participation in HIV program committees or other planning bodies
- Needs assessments, focus groups, or satisfaction surveys that collect information from consumers to help guide and evaluate service delivery

Standards

Client Rights and Responsibilities

Purpose: Providers must have policies and procedures that protect the rights and outline the responsibilities of the clients and the provider. Providers must demonstrate the capacity to ensure that services are accessible and relevant to all PLWH, including linguistic and cultural minorities and people with disabilities.

Standard	Criteria	Documentation
HCS provider will ensure that clients are aware of and understand their rights and responsibilities as consumers of HIV services.	HCS provider will review and provide the client a copy of the Client Rights and Responsibilities Statement	HCS providers' Client Rights and Responsibilities Statement is signed and dated by client.
There will be no barriers due to client disability.	HCS provider complies with Americans with Disabilities Act (ADA) Criteria.	HCS provider has a written ADA policy.
HIV providers will provide core medical and support services without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the client.	Provider will provide services to all qualified individuals without discrimination based on ability to pay for services.	HCS provider's Clients Rights and Responsibility Standards includes a statement that individuals can receive services regardless of ability to pay for services and without regard to the current or past health conditions.

HCS providers will provide services in a setting that is accessible to clients.	Low-income clients must be able to access services.	HCS provider demonstrates that the facility is accessible by public transportation or provide transportation assistance.
HCS provider will not discriminate on any basis prohibited by law.	Provider provides services to all qualified individuals without discrimination on any basis prohibited by law. This includes HIV infection, race, ethnicity, creed, color, age, sex, gender, gender identity or expression, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap, substance abuse, immigrant status, political affiliations or belief, ex-offender status, unfavorable military discharge, membership in an activist organization	HCS provider has a Nondiscrimination Policy.
		HCS provider maintains record of individuals refused services with: - Reasons for refusal specified - Complaints from client - Complaint review - Decision reached

Grievance Policy

A subrecipient's grievance policy must outline a client's options if they feel that the subrecipient is treating them unfairly or not providing quality services. The grievance procedure must be posted and visible to clients and include:

- Steps a client must follow to file a grievance
- Subrecipient procedure for handling grievances
- Information on how a client can appeal the decision if the grievance is not settled to his or her satisfaction

Agencies must confidentially maintain files of eligible individuals refused services with reasons for refusal specified. Subrecipient files must include formal complaints from clients, with documentation of complaint review and decision reached.

Grievance

Purpose: Providers must have policies and procedures that outline client grievance procedure.

Standard	Criteria	Documentation
HCS provider will provide a process to address client grievances at every level of their subrecipient.	HCS provider will develop and disseminate written client grievance procedures. These grievance procedures must include: - Steps a client must follow to file a grievance - How the grievance will be handled - A client's right to appeal	HCS provider has a written grievance policy.
	Provider has promptly identified issues through investigation of client grievances.	Provider logs all grievances.
		Notes regarding subsequent investigations, findings, and actions are available for inspection.

Transition or Discharge Policy

Subrecipient must have a transition/discharge policy that outlines how they will attempt to achieve continuity of care for clients leaving their agency. The discharge policy must include reasons for transitioning and discharging clients.

Transition or Discharge

Purpose: Providers maximize continuity of care through comprehensive and well-defined discharge and transition procedures.

Standard	Criteria	Documentation
HCS provider will ensure continuity of services for all clients to the best of their ability	HCS provider will develop and disseminate written client transition and discharge procedures. These transition or discharge procedures must include: - Steps a client must follow to transition to another subrecipient - Steps the subrecipient must follow to transition or discharge a client. - A client's right to appeal	HCS provider has a written transition and discharge policy.
	Provider has promptly identified issues around transitioning or discharging a client.	Provider logs all transitions and discharges. Notes regarding subsequent investigations, findings, and actions are available for inspection.

Culturally and Linguistically Appropriate Services

The National Standards on Culturally and Linguistically Appropriate Services (CLAS) requires agencies to make available easily understood patient-related materials. Providers must post signage in the languages of the commonly encountered group(s) represented in the service area.

Purpose: Providers will reduce barriers to care or increase access to care through the provision of culturally and linguistically appropriate services.

Standard	Criteria	Documentation
HCS provider will assure the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff. Family and friends should not provide interpretation services, except on request by the client.	HCS provider ensures access to services for clients with limited English skills by - Bilingual staff who can communicate directly with clients in preferred language - Face to face interpretation provided by qualified staff, contract interpreters, or volunteer interpreters - Telephone interpreter services for emergency or infrequently encountered languages If client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent. The family member or friend must be: - Over the age of 18 - Able to communicate fluently in both English and the native language of the client Programs must provide educational materials and documentation (consents, grievance procedures) in the native language of the population's services, consistent with federal Limited English Proficiency guidance.	HCS provider documents access to services with limited English skills through the following: - For bilingual staff: Resumes on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting - For contract or volunteer interpreters; copy of certifications on file - For telephone interpreter services: Listings on file - For family or friend interpreter services: Consent form signed by client and maintained in client file
HCS provider will develop written policies and procedures regarding cultural competence, including a listing of persons involved in the development of these policies and procedures.	HCS provider must develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services.	HCS provider has a written Cultural Competency policy.

Records Management and Reporting

HCS staff must document information for the purposes of coordinating client services, recording referrals and resources provided, meeting contractual requirements for each funding source, and monitoring and evaluating services. Providers must use CAREWare to track activities, enter case notes, update client demographics, housing, insurance, and income status, document service provision, and report performance measures.

Narrative Reports

1. Narrative reports shall include the following components:
    a. Changes to service delivery plan
    b. New access points for HCS funded direct services
    c. Participation in the Washington HIV planning process
    d. Program accomplishments, for example:
        i. Outreach
        ii. Linkage to care
        iii. Success in reaching underserved populations
        iv. Success in meeting or exceeding planned outcome targets
        v. Effective strategies used to recruit, train, or maintain employees
        vi. Enhanced linkages with other HIV Community Services programming
        vii. Coordinating services with other health-care delivery systems
        viii. Evaluating the impact of HCS funds and making needed improvements.
        ix. Documenting clients served and outcomes achieved
    e. Challenges and lessons learned, for example:
        i. Tools and protocols
        ii. Health disparities
    f. Technical Assistance needed

NOTE: DOH will run routine CAREWare data summaries in lieu of providers submitting quarterly demographic data. Providers must submit aggregate population-based PAHR data quarterly.

Providers must submit reports by the last working day of the month following the quarter's end.

Quarter One: January 1, 2017 – March 31, 2017	Report Due: April 28, 2017
Quarter Two: April 1, 2017 – June 30, 2017	Report Due: July 31, 2017
Quarter Three: July 1, 2017 – September 30, 2017	Report Due: October 31, 2017
Quarter Four: October 1, 2017 – December 31, 2017	Report Due: January 31, 2018

Personnel

Skills and Knowledge

HCS personnel must have appropriate credentials under the laws and regulations of the state of Washington or should demonstrate sufficient mastery of the following areas of skill and knowledge essential to manage the complexity of client HIV-related medical needs and conditions:
- Medical terminology commonly associated with cases of HIV or AIDS
- The medications used for the treatment or prevention of HIV and associated conditions
- Common laboratory procedures associated with HIV care and the meaning of the associated lab results
- Eligibility and enrollment processes for the forms of third party payment available to PLWH, including the Early Intervention Program, Washington's HIV Insurance Assistance Program, Qualified Health Plans through the HealthPlanFinder, WSHIP, Medicaid, Medicare, and private health insurance
- Laws and regulations regarding the sharing of confidential medical information, including HIPAA
- Operating in a supporting role to a licensed provider of HIV medical care, without violating laws and regulations concerning the actual delivery of health care services

HCS personnel must also maintain proficiency regarding the following care-related services and they must collaborate with the providers of such services:
- Washington's Early Intervention Program (EIP ADAP)
- Washington's HIV Insurance Assistance Program, currently provided by Evergreen Health Insurance Program (EHIP)
- The Housing Opportunities for People with AIDS (HOPWA) program, administered by the Washington State Commerce Department

HSC personnel must have:
- Clear and updated job descriptions
- An orientation
- Supervision
- Appropriate ongoing training opportunities, including:
  o Clinical consultations
  o Review of client files
  o Training in cultural competency

Providers are responsible for providing staff with supervision and training to develop capacities needed for effective job performance. Staff must have previous experience, or a plan for acquiring experience, in providing HCS.

Job Descriptions

HCS personnel must receive and sign a written job description that outlines the specific minimum requirements for their position.

The supervisor's job description must state that they:
- Understand Statewide HCS Standards and requirements
- Review personnel job descriptions every 12 months and update as needed.
- Have contact with HCS staff at least weekly
- Have education, knowledge, and skills to support HCS staff
    - Bachelor's degree and 3 years relevant experience

The job description for HCS staff providing Engagement Services must state that they:
- Understand Statewide HIV Case Management Standards and requirements
- Have knowledge of HIV/AIDS care service delivery system or experience in a related field
- Receive regular, direct supervision
- Have education, knowledge and skills sufficient to fulfill the functions and scope of their position
    - Have a Bachelor's degree and 1 year experience

The job description for HCS staff providing Retention Services must state that they:
- Understand Statewide HIV Case Management Standards and requirements
- Have knowledge of HIV/AIDS
- Receive regular, direct supervision
- Have education, knowledge, experience and skills sufficient to fulfill the functions and scope of their position
    - Have a High School diploma or equivalent

The job description for HCS staff providing Navigation or Assistor Services must state that they:
- Understand Statewide HIV Case Management Standards and requirements
- Have knowledge of HIV/AIDS
- Receive regular, direct supervision
- Have education, knowledge, experience and skills sufficient to fulfill the functions and scope of their position
    - Have a High School diploma or equivalent

Orientation
Agencies must provide a structured orientation within 1 month of hire. Orientation must address:
- Overall operation of the program and subrecipient
- Job duties/responsibilities
- Subrecipient policies and procedures
- Confidentiality
- Code of ethics
- Professional boundaries
- Introduction to local resources and programs
- Review of client eligibility and intake process
- Required documentation in client files

- Training needs and annual training requirements
- Quality management
- Coping with job related stress/preventing burnout
- Crisis management

Supervision

Supervisors must provide HCS staff with guidance and supervision. This must include:

- Weekly contact as well as intentional supervision meetings with each staff person at least 2 times per month
- Evaluating job performance at least once every 12 months

Training

Within 6 months of hire, HCS personnel providing services to PLWH must attend DOH sponsored training on the Statewide HIV Case Management Standards. In addition, full time case managers must receive a minimum of 20 hours of job related trainings per year. The training requirement for part time case managers is equivalent to the percentage of FTE (e.g., 0.5 FTE = minimum of 10 hours training per year).

DOH expects subrecipient staff to keep a log of their trainings. Subrecipients should collect and store in personnel files staff training logs annually.

 Examples of job related trainings include:

- Mental Health/Trauma Informed Care
- Chemical Dependency
- Cultural Competency
- HIV Treatment and Trends
- Tobacco Cessation
- HIV Prevention
- Harm Reduction
- Retention in Care Training (ARTAS)
- Ethics

Clinical Consultation

In addition to the trainings listed above supervisors must provide or arrange clinical case consultations with case management staff at least quarterly.

Review of Client Case Files

Supervisors must review a representative sample of all client case files quarterly for compliance with HCS Standards. In addition, peer review of client files is strongly encouraged.

DOH uses the following formula to determine a "representative sample":

      For Charts 0-50 charts = 50% of charts reviewed

For charts 51 - 100 = 25% of charts reviewed

For charts 101- 500 = 10% of charts reviewed

For charts 501- 5000 = 5% of charts reviewed

If sample size is 30 charts, total reviewed = 15 charts quarterly

If sample size is 260 charts, total reviewed = 25 + 10 + 16 = 51 charts quarterly.

If sample size is 480, total reviewed = 25 + 10 + 38 = 73 charts quarterly.

Cultural Competence

Subrecipient staff must receive training on the National Standards on Culturally and Linguistically Appropriate Services (CLAS). This is to ensure that services provided by subrecipient staff are culturally and linguistically appropriate. Training of CLAS standards must take place during initial orientation. In addition to CLAS training, subrecipient staff must receive training on specific populations (i.e.: foreign-born black, transgender, geriatric, youth, etc.) based on the needs of an agencies caseload. Trainings may include in person consultations, webinars, or training videos.

At least 8 hours of the required 20 hours of training for full time subrecipient staff must include cultural competency. Agencies are required to conduct annual assessments of their cultural competency and develop improvement plans based on the results of the assessment. The link to CLAS standards is http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

PLWH Case Load Management

A PLWH case manager must carry a reasonable caseload to effectively interview, assess, plan for, and support the client. As a caseload increases, the case manager has a decreasing ability to perform ongoing case management activities such as follow-up, monitoring, and reassessment. Both the subrecipient and the case manager have a responsibility to remedy issues that may have a negative impact on the quality of care. Regardless of the size of the caseload, the subrecipient must demonstrate to DOH how it will maintain quality of care over the long term.

Client Intake for PLWH services- Policies and Procedures

During the intake process, staff will:

- Obtain consent for core medical and support services
- Explain the subrecipient's eligibility policy
- Explain the subrecipient's confidentiality policy
- Explain the subrecipient's client rights and responsibilities policy
- Explain the subrecipient's grievance policy
- Explain subrecipient's reassessment of eligibility policy
- Explain the subrecipient's transition/discharge policy
- Explain client's freedom to choose a provider (Medicaid)
- Obtain client signatures on needed Release of Information (ROI) form(s)

Program staff must document that the client received, or staff offered a copy of all of the above documents. Documentation can consist of a sentence at the end of the rights and responsibilities policy (e.g. "I acknowledge that I have read and understand these rights and responsibilities and I have been offered a copy of all subrecipient policies. I consent for HCS services at *blank* subrecipient").

Fiscal

The subrecipient must use the contract budget categories as the expense categories. The subrecipient must abide by these conditions:

- DOH funds are "cost reimbursement" funds. DOH will not make payment in advance or in anticipation of services or supplies provided. This includes payments of "one-twelfth" of the current fiscal year's funding.
- No program funds shall be used to provide items or services for which payment has been made or reasonably can be expected to be made, by third party payers, including Medicaid, Medicare, the Early Intervention Program (EIP) or State or local entitlement programs, prepaid health plans or private insurance. Therefore, subrecipients providing case management services must enroll eligible clients in Medicaid. Subrecipients will not use HCS funds to pay for any Medicaid-covered services for Medicaid enrollees.
- The subrecipient cannot charge more for HIV services than allowed by Ryan White legislation.
- Subrecipients may not use HCS funds to provide cash incentives for activities such as participation in needs assessments, focus groups, or surveys.
- Subrecipients that provide case management services shall assist clients to enroll in EIP.
- If direct provision of service is not possible or effective, providers can issue vouchers to meet the need for such services. Clients can only exchange the vouchers for a specific service. Subrecipients must administer voucher programs to assure that recipients cannot readily convert vouchers into cash.
- Service providers shall not use Ryan White Program Part B funds to pay for scheduled appointments if a client fails to keep the appointment.

Invoices

Subrecipients submit signed monthly invoices to HIV Client Services. Agencies must submit a monthly summary of expenses by the last working day of the following month. HIV Client Services must receive the final invoice within 30-days of the end of the contract period. Each invoice voucher must indicate that it is for services rendered in performance under a Washington State Department of Health contract for HIV care services. An authorized signatory of the subrecipient must sign the "Vendor's Certificate" portion.

HIV Client Services does not pay a subrecipient's invoice until the subrecipient has returned a signed copy of the contract to the Department's Contract Office. After receiving an executed copy of the contract, the contract coordinator sends a master invoice to each subrecipient.

Upon receipt of an invoice, the contract manager or contract coordinator reviews each invoice by line item against the approved subrecipient budget. The contract manager checks for discrepancies, such as over-billings, improper costs, and line items charges.

The Fiscal or Contract Coordinator assures that the contracting subrecipient's representative has signed and dated the invoice and enters the billed amount into an Excel spreadsheet. After comparing the invoice to the contract budget and verifying that the services and amounts are correct, the Fiscal Coordinator sends the invoice and supporting documentation to the Grants Office, who processes it for payment. Staff approves invoices and submits to the Grants Office within 30-days of receipt of a properly submitted invoice. The Grants Office takes up to five days to process the invoice.

Allowable Costs

Sound fiscal management begins with understanding which types of expenses that the subrecipient can pay using contract funds. Allowable costs are expenses specifically permitted (or not prohibited) by the laws, regulations, principles and standards of the program, the state, and the federal government.

To help you decide if costs are allowable, ask these questions:
Is the expense:

- Necessary to implement the program
- Reasonable, would a prudent person think the cost is appropriate
- Allocable to the tasks or objectives in the contract's Statement of Work
- Legal
- Compliant with program rules

The following list will help you determine whether your program expenses are allowable. The list includes costs that subrecipients commonly incur, or are the subject of frequent questions or discussions. Use this list as a guideline. Each program has specific costs that are allowable and may not be on this list. If you have questions, contact the contract manager to find out if it is allowable.

Advertising and Public Relations Costs - *generally unallowable*
<u>Advertising</u> costs are the expenses associated with the costs of advertising media (magazines, newspapers, radio and television, direct mail, exhibits, electronic or computer communication) and associated administrative costs. Contact your contract manager for pre-approval when considering advertising.

<u>Public relations</u> are activities dedicated to maintaining the image of the program or maintaining or promoting understanding and favorable relations with the community or public. For DOH, public relations costs are potentially allowable when:
(1) The activity is part of your approved Statement of Work
(2) You are communicating with the public and press pertaining to specific activities or accomplishments that result from your program.

Advisory Council - *allowable*
Costs incurred by advisory councils or committees are allowable as a direct cost with written preapproval by the contract manager.

Alcoholic Beverages or Marijuana - *unallowable and should <u>never</u> appear on receipts*

Audit Costs and Related Service - *allowable.*
The costs of audits required by, and performed in accordance with Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards are allowable. Other audit

costs are allowable if included in a cost allocation plan or indirect cost proposal, or if specifically approved by the contract manager.

Bad Debts **-** *unallowable*

Bonuses **-** *unallowable*

Communication Costs: *allowable*

Costs incurred for telephone services, local and long distance telephone calls, telegrams, postage, messenger, electronic or computer transmittal services and the like are allowable. However, you will need to check if these expenses are already included in your indirect costs.

Compensation (Salaries, Wages & Fringe Benefits) **-** *allowable*

Personnel costs such as salaries, wages, and fringe benefits are allowable if the charges are for work performed directly on tasks in your Statement of Work.

Donations and Contributions to Another Organization - unallowable

Contributions or donations (including cash, property, and services) are unallowable costs.

Entertainment costs **-** *unallowable*

Costs of entertainment, including amusement, diversion, and social activities and any costs directly associated with such costs (such as tickets to shows or sports events, meals, lodging, rentals, transportation, and gratuities) are unallowable.

Equipment *- allowable*

Equipment means an article of nonexpendable, tangible personal property having a useful life of more than one year and for DOH Infectious Disease accounting purposes, has a per-unit cost equal to or greater than $5,000. *Please note that the subrecipient must purchase and receive equipment by the end of the contract period. Failure to pay for and receive these items before the contract end date will result in denial of charges.* The title (documented ownership) of the equipment remains with DOH unless otherwise specified.

Food and Refreshments **-** *generally unallowable, with exceptions*

Food and refreshments are not allowable direct costs, unless provided in conjunction with allowable meetings, whose primary purpose is the dissemination of technical information. If not sure, contact your contract manager for written preapproval.

Fines, Penalties, and Late Fees **-** *unallowable*

Fundraising **-** *unallowable*

Goods or Services for Personal Use **-** *unallowable*

Lobbying - *unallowable*

Subrecipients cannot use funds to:

- Influence the outcome of referendum, initiative, or similar procedure, through in-kind or cash contributions, endorsements, publicity, or similar activity
- Towards a political party, campaign, or political action committee
- Attempt to influence the introduction, enactment, or modification of state or federal legislation through direct or grassroots lobbying

Maintenance, Operations, and Repairs **-** *allowable*

Subrecipients may use DOH funds to cover the cost of utilities, insurance, security, janitorial services, upkeep of grounds, necessary maintenance, normal repairs, and alterations, and the like if they:

- Keep property in an efficient operating condition
- Do not add to the permanent value of property or appreciably prolong its intended life
- Are not otherwise included in rental or other charges for space

Materials and Supplies - *allowable*

Costs incurred for materials and supplies that are necessary to carry out the activities in the contract's Statement of Work are allowable. *Please note that subrecipients must purchase and receive materials and supplies by the end of the contract period. Failure to pay for and receive these items before the contract end date will result in the denial of charges.*

Subrecipients must invoice for purchased materials and supplies at their actual prices, net of applicable credits. Subrecipients must charge withdrawals from general stores or stockrooms at their actual net cost under any recognized method of pricing inventory withdrawals, consistently applied. Shipping charges are an allowable part of materials and supplies costs. Subrecipients can only charge materials and supplies as a direct cost if they used them for the activities in the Statement of Work.

The term "Supplies" covers items that have a per-unit cost of less than $5,000.

Meetings and Conferences **-** *allowable*

Costs of meetings and conferences, when the primary purpose is the dissemination of information, are allowable. Remember entertainment costs are not allowable. Out-of-state or in-state meetings that cost more than $500 require written, pre-approval from the contract manager.

Mortgage Payments – *unallowable*

Publications and Printing **-** *allowable*

Publication costs – including the costs of printing, distribution, promotion, mailing, and general handling are allowable costs if they are allocable to program objectives and the contract's Statement of Work.

Recruiting Costs **-** *allowable*

Within reason, the costs of "help wanted" advertising and the cost of recruiting new employees is allowable.

Rental Cars - unallowable

Rental cars are unallowable, unless the contract manager has given pre approval prior to use of the rental car.

Rental Cost of buildings and equipment - *allowable*

Rental costs are allowable to the extent that the rates are reasonable considering: (1) rental costs of comparable property, if any; (2) market conditions in the area; and (3) alternatives available.

Subrecipients should review rental arrangements periodically to determine if circumstances have changed and other options are available.

Selling and Marketing: - u*nallowable*

Costs of selling and marketing any products or services are unallowable.

Severance Pay - *allowable*

Severance pay is allowable for terminated personnel to the extent that law or employer-employee agreement requires such payments. They are also allowable if established policy constitutes an implied agreement on the subrecipient's part, or by circumstances of the particular employment.

Supplies - *allowable*

Costs incurred for supplies to carry out the Statement of Work in the contract are allowable. *Please note that subrecipients must purchase and receive supplies by the end of the contract period. Failure to pay for and receive these items before the contract end date will result in the denial of charges.*

Training costs - *allowable*

The cost of training provided for employee development is allowable.

Travel costs - *allowable*

Travel costs are the expenses for transportation, lodging, subsistence, and related items incurred by employees who are in travel status on official business of the contractor. Travel outside of the Washington State requires prior written approval from the contract manager. See Travel Guidelines for more details and the allowable amounts.

Vouchers, or Gift Cards - *allowable*

Providers may provide support services such as medical transportation, food bank/home-delivered meals, or housing services through vouchers or gift cards. Providers must securely store and securely transfer vouchers, or gift cards. Providers will keep vouchers or gift cards in locked and secured storage until they give them to clients.

Fiscal – Travel Guidelines

Subrecipients must comply with Office of Financial Management (OFM) travel management requirements and restrictions (http://www.ofm.wa.gov/policy/10). Agencies are to ensure that travel costs incurred are directly worked related, obtained at the most economical price, and both critical and necessary for contract funded business.

Travel Guidelines

To ensure smooth processing and reimbursement of Infectious Disease related travel expenses, there are two important considerations:
- Employees should follow their employer's rules and policies regarding travel allowances and reimbursement requirements.
- Department of Health (DOH) can only reimburse for allowable travel expenses up to the maximum allowed amount set by the OFM for in-state travel and General Services Administration (GSA) for out of state travel
    o A map of the current in-state per diem rates can be found at:
      http://www.ofm.wa.gov/resources/travel/colormap1015.pdf
    o A map for the current out of state per diem rates can be found at:
      http://gsa.gov/portal/category/100120

Employees should claim travel expenses using the process their employer requires. Employees should also provide DOH with the necessary travel expense documentation required by the program. DOH does not reimburse for travel directly. Employees submit a Travel Expense Form and documentation to their employer for travel expenses. The employer then submits an A-19 Invoice Voucher requesting reimbursement of these expenses. Following the guidelines below will ensure that the subrecipient receives reimbursement for all allowable travel expenses.

Travel Expense Voucher

Employees must complete the DOH Infectious Disease Travel Form completely by providing as much detail as the expense voucher requests. This includes the purpose of the trip, the location, and the dates and times of travel.

The following items must be included:
- **Mileage**: Total miles claimed from destination to destination
- **Meals**: Total claimed for breakfast, lunch, or dinner on each travel day
    o If not using employer or OFM per diem amounts, subrecipient must submit detailed receipts totaling the amount claimed as backup
- **Lodging**: A detailed receipt of lodging expenses including dates of stay, rate per night, taxes, fees, and specific charges is required. Room service charges should not be included. DOH will not reimburse for room service charges.
- **Miscellaneous Expenses (tolls, parking, baggage, etc.):** Subrecipient must provide receipts
- **Departure and return times:** Per state rules, travelers must document their departure and return times for all trips.

- o Departure time is the time employee left home or place of business on the first day of the trip, whichever is later. If employee did not go to place of work on that day, then use the time left home.
- o Return time is the time employee arrived home or place of business on the final day of travel, whichever is earlier. If employee did not return to place of work on that day, then use the time arrived at home.
- o Include departure and arrival times on the DOH Infectious Disease Travel Expense Form.

Lodging

·DOH will reimburse for lodging expenses when the temporary duty station is more than fifty miles (most direct route) of the closer of either the traveler's official residence or official station.

·Department of Health can reimburse for lodging up to the maximum allowed amount set by OFM or GSA.

·Taxes and fees associated are not included in the OFM lodging rates, and are in addition to the room rate.

·DOH must preapprove Internet access fees. Typically, DOH will approve internet access if necessary for administrators, but not for other staff.

·If lodging is required that exceeds the set OFM or GSA amount, then DOH must pre-approve the expense. For example, if a conference at a hotel that charges over per diem, DOH could reimburse with pre-approval. DOH will usually allow when the cost of staying at a separate venue requires additional transportation expenses that would result in higher costs than staying at the conference venue.

·If DOH gives approval, the traveler must select the most economical room available under the circumstances.

·DOH will not give approval if lodging exceeds 150% of per diem.

·A detailed receipt is required for all lodging expenses (shows cost of room, fees, taxes, etc.).

·If employees can reasonably travel in the same day as a one-day meeting, DOH will not reimburse for lodging.

Meals:

Department of Health (DOH) can only reimburse for the cost of meals up to the maximum allowed amount set by the OFM or GSA. These are "meal per diem rates". If a subrecipient does not use per diem rates, the subrecipient must provide meal receipts. However, DOH will not reimburse for higher than the per diem rate.

Meals are only reimbursable if the staff member is in travel status. This includes overnight travel or day trips.

- Overnight travel status begins when the employee departs for their trip and ends when they return to their home or place of work.
- Day trip travel status requires the employee to work three hours or more beyond their regularly scheduled work hours (Three Hour Rule).

- Travelers must be in travel status during the meal period(s) to qualify for reimbursement for meal(s). Employees must not work beyond a meal period for the sole purpose of gaining meal reimbursement.
- Receipts for meals:
    - If per diem (state, federal, or employer allowance, whichever is less) is used, a meal receipt is **not** required – unless required by the employer.
    - If the employer reimburses based on the actual cost of the meal, not to exceed the state or federal per diem, then DOH requires a copy of the detailed receipt(s). DOH will not accept a credit card receipt.
- DOH will not reimburse employee meal if the event includes a meal.
- If a hotel provides a hot breakfast as part of the stay, it is a provided meal and DOH will not reimburse.
- Incidentals, such as coffee and snacks, purchased separate from a meal are not reimbursable.
- DOH requires detailed meal receipts. Credit card receipts are not detailed and therefore are not an acceptable form of documentation. Receipts must show what the employee purchased.
- The state allowed per diem amount per meal *includes taxes and tip* so DOH will not reimburse if these items exceed the allowed per diem.
- Also remember:
    - Alcoholic beverages should **<u>NOT</u>** be on receipts and DOH will not reimburse.
    - If the receipt shows the employee meal and another person's meal, DOH requires a **<u>SEPARATE</u>** receipt showing only the employee's meal. DOH will only pay for the approved traveling staff member's meal expenses (even if combined meal costs for one approved traveler and companion(s) does not exceed the allowed maximum amount).

Mileage:

Vehicle Reimbursement: DOH will reimburse for subrecipient use of personal vehicle at the current state rate. DOH can reimburse for the use of subrecipient's vehicles (SUV, van, bus) up to the allowed maximum amount set the by the employer. DOH requires written verification of the employer cost per mile unless the cost is less or equal to the state mileage rate.

- **Carpooling**: If staff members are carpooling, only one staff member can claim mileage for the duration of the trip. DOH encourages carpooling to maximize resources.
- **Rental Car**: DOH will not reimburse for the use of rental cars except in rare cases. All rental cars must be pre-approved.

Miscellaneous:

- **Tolls:** DOH will reimburse for bridge and ferry tolls but will require a detailed receipt. DOH will not reimburse for High Occupancy Tolls.
- **Parking:**
    - If parking at a hotel event, the parking listed on the lodging receipt is acceptable
    - DOH will reimburse for other parking and a detailed parking receipt is required
    - DOH will not reimburse for valet parking. If valet parking is used, DOH will only reimburse the standard rate

Fiscal – Travel Guidelines

Airfare:
Staff may travel by air (economy class), but a detailed receipt showing all costs is required for reimbursement. Use caution when making online reservations. DOH recommends booking directly with the airline rather than using a travel service. If you do book online, be sure you print the actual receipt showing the total amount of the fare and payment – and not the confirmation.

Baggage: DOH will reimburse for up to one checked bag. A receipt showing this expense is required.

Advance Travel:
- DOH cannot reimburse for advance travel because travel advances are estimates of travel expenses.
- DOH cannot reimburse an employer for more than what the employer reimbursed its employee.
- Employers must request reimbursement from DOH after subrecipient has reimbursed the employee.

Receipts and Invoices:
- Provide copies of all detailed receipts or invoices for requested travel expenses. Copies of credit card receipts or bank statements are not appropriate backup.
- Provide copies of completed travel expense forms and vouchers.
- Provide a copy of the Transaction Recap showing only who or what DOH funding paid.

Out-of-state Travel: Prior approval is required to travel out of state. Email the program two weeks or more in advance of the requested travel with the following information:
- Name of traveler(s)
- Name of conference or meeting
- Dates of travel including beginning and ending times (attach information or a link to meeting or conference if available)
- Justification for attending the conference or meeting
- Estimated cost of Travel

Travel before and after meetings or conferences.
- If you can reasonably travel roundtrip to attend a one-day meeting or conference the same day, you are required to do so.
- If overnight travel is required for a one-day meeting, DOH requires prior approval.

If traveling to or from a meeting or conference on the same day is not reasonable, you may travel up to either one day before or one day after the meeting or conference. "Reasonable" is what a good steward of public funds would do. This also applies to lodging. If you can reasonably travel to and from a meeting or conference in a day, DOH will not approve or reimburse lodging.

Traveling more than one day before or after a meeting or conference is <u>not</u> an allowable expense and DOH will <u>not</u> be reimburse. The traveler pays <u>all</u> other costs associated with staying the extra day(s).

Title XIX Medical Case Management

The intended outcomes of Title XIX HIV/AIDS Targeted Medical Case Management are to assist persons living with HIV/AIDS to:

- Gain and maintain access to primary medical care and treatment
- Gain and maintain access to antiretroviral medications
- Maintain adherence to treatment and medications
- Live as independently as possible

Health Care Authority (HCA) has an agreement with the Department of Health (DOH) to administer the HIV/AIDS Case Management program for eligible clients (WAC 182-539-0300). HIV Client Services oversees the daily operation of the Title XIX HIV/AIDS Case Management Program.

Client Eligibility

To be eligible for Title XIX HIV/AIDS Case Management services, a client must

- Have a current medical diagnosis of HIV or AIDS
- Not be receiving concurrent HIV/AIDS case management services through another program
- Require assistance obtaining and effectively using necessary medical, social, and educational services; or need 90 days of continued monitoring
- Have a benefit service package that covers HIV/AIDS case management

A client enrolled in a Medicaid managed care organization (MCO) is eligible for Title XIX HIV/AIDS Case Management Services. HCA does not require HCS providers to obtain a referral from the client's MCO.

Reimbursement for Services

The Health Care Authority uses a fee-for-service model to reimburse providers for Title XIX Targeted HIV Case Management Services. To receive payment for services rendered to a specific client, the provider must have

- Reassessment of eligibility information for that client dated within six months of services provided
- An active ISP reassessed within six months of date of services
- Provided relevant case management services for that client within the month billed

Title XIX does allow for reimbursement of monitoring services for up to three consecutive months.

Billable Services

(See also WAC 182-539-0300)

HCA pays HIV/AIDS case management providers for the following services. The definitions of services are in the Case Management- Standards of Care section of this manual.

- New Client Initial Comprehensive assessment
- Comprehensive Assessment for a client who has a 50% change in need from the initial assessment
- Full month case management per client, per month
    o Individualized service plan in place for 20 or more days in that month
- Partial month case management per client, per month

- o Individualized service plan in place for fewer than 20 days in that month
- o Partial month payment allows for payment of two case management subrecipients when a client changes from on provider to another during the month
- Monitoring
    - o Monitoring is a service reserved for stable clients who no longer need an ISP with active elements, but who have a history of recurring need and will likely require active case management in the future
    - o Case management subrecipients may bill up to 90 days of monitoring after the last active service element of the ISP has been completed, if the following criteria have been met:
        - ▪ The subrecipient documented the client's history of recurring need
        - ▪ The subrecipient assessed the client for possible future instability
        - ▪ The subrecipient contacted the client monthly to monitor the client's condition
    - o A client can shift from monitoring to active case management if there is a documented need to resume active case management

State Match

DOH contracts with HCA to administer Washington's Title XIX Targeted HIV Case Management program. DOH uses general fund state dollars to meet the state Medicaid match for these services. This system will remain in place as long as DOH has sufficient state general funds to meet Medicaid match.

To receive payment from HCA, providers must:

- Have a signed contract with the Health Care Authority (HCA) to provide Title XIX HIV Medical Case Management for eligible clients
- Follow Washington case management standards
- Adhere to the Title XIX (Medicaid) HIV/AIDS Case Management Billing Instructions
- Adhere to the following system for meeting Medicaid match:
    - o Providers will bill HCA for Title XIX case management services
    - o HCA will pay providers for services rendered
    - o HCA will bill DOH for the state match
    - o DOH will pay the state match to HCA
    - o Providers will apply the amount reimbursed by HCA, which is program income, to the HIV case management program
- Have clients sign Release of Information Forms granting DOH permission to review client charts and client level data for quality assurance and evaluation purposes.

Payer of Last Resort

Service providers must assure that they have made reasonable efforts to secure non-HCS funds whenever possible for services to individual clients. DOH expects providers to pursue eligibility for other funding sources to extend finite HCS resources. This means subrecipients may not use DOH funds to provide items or services paid by third party payers, including:

- Medicaid
- Medicare
- Other state or local entitlement programs
- Prepaid health plans
- Private insurance

It is incumbent upon providers to ensure that eligible individuals enroll in Medicaid. Medicaid enrollees cannot use DOH funds to pay for Medicaid-covered services. If a client is eligible for Medicaid, the provider must retroactively bill Medicaid for HCS provided during the time in which eligibility was being determined.

If HIV/AIDS funding is available from other sources, such as General Revenue Patient Care Network and HOPWA, DOH does not require that each of these funding sources be exhausted prior to accessing HCS funds. However, providers must coordinate payment for eligible services across funding streams. HCS funds can wrap around health care and supportive services not covered by public or private health insurance plans.

Fiscal – Reconciliation of Program Income or Other Revenue Sources

Reconciliation of Program Income

Providers must develop their own procedures for demonstrating that they are using HCS funding as a last resort. One possible procedure is reconciliation between HCS revenues (e.g. Title XIX Targeted HIV Medical Case Management) and expenditures. The steps are as follows.

1. Calculate actual and eligible direct service costs.
2. Calculate total available revenues from non-HCS funding (first resort funding).
3. Subtract ineligible costs (see Fiscal – Allowable Costs) from your available first resort funding. This gives you the total available first resort funding of direct service costs.
4. Subtract total available first resort funding from the total eligible direct costs calculated at number 1 above to determine the amount of direct costs provider will bill to HCS.
5. Calculate indirect costs on the total eligible direct costs calculated in number 4 above.

Provider Snowy Woods		
Case Management Program		
Budget Categories		Direct Costs
	Wages	$7,000
	Benefits	$1,700
	Travel/Mileage	$ 650
	Supplies	$ 145
	Equipment	$ 300
	Other	$ 550
Total Direct Costs		$10,395
Program Income (see below)		
	Title XIX Case Management	$6,000
Total Title XIX Payment		$6,600
Amount Billable to HCS		
	Total Direct Costs	$10,395
	Title XIX Payment	$ 6,600
	Subtotal	$ 3,795
	26% Indirect	$ 987
	Total Billable to DOH	**$ 4,782**

Fiscal – Reconciliation of Program Income or Other Revenue Sources

Standards

Payer of Last Resort

Purpose: Provider must use HCS funds as payer of last resort. Providers must require and maintain documentation that they used HCS funds as payer of last resort.

Standard	Criteria	Documentation
HCS providers assure client is not eligible for other funding sources (Medicaid, Medicare, health insurance, Early Intervention Program).	HCS provider will screen client for insurance coverage and eligibility for third payer programs, and assist the client to apply for such coverage.	HCS provider documents screening for eligibility for payment by other funding sources (Medicaid, insurance, Early Intervention Program).
		For services that could be billed to a third party payment source, but not so billed, the HCS provider documents one of the following: · The potential source of third party payment would require premium or out-or-pocket costs that are unaffordable to the client · The services available through the third party source of payment are inaccessible · The services available through the third party source would fail to meet Washington's Standards of Care.
HCS providers assist clients to access services when they have exhausted other options.	Clients agree to plan for self-sufficiency if the client has requested or received support service assistance four times within a one-year period.	HCS provider documents financial goals on client's care plan.
HCS receiving payment for providing services will deduct program income prior to billing DOH.	HCS provider develops procedures for demonstrating that they are using HCS funding as a last resort	HCS provider documents that they are using program income funds prior to billing HCS.
		HCS provider documents billing for payment by other funding sources for eligible clients.

Fiscal Monitoring

Fiscal monitoring assesses whether a subrecipient uses DOH funding efficiently and for approved purposes. With effective fiscal monitoring, DOH tracks the timely expenditure of DOH funds. This type of monitoring includes regular review and assessment of subrecipients' expenditure patterns and processes to ensure adherence to Federal, State, and local rules and guidelines on the use of DOH funds.

Examples of how DOH links program monitoring and fiscal monitoring are as follows:
- Requiring program reports to accompany reimbursement invoices before processing of payment
- Requiring fiscal and program documentation to reimburse providers on a unit cost basis
- Using monitoring visits that include a program audit and a fiscal audit

Grantors, the Office of Financial Management, and the State Auditor's Office hold the Washington State Department of Health accountable for the expenditure of funds under its control. As part of the Department's comprehensive approach to contract management, the DOH Fiscal Monitoring Unit (FMU) conducts on-site fiscal monitoring site visits for HCS agencies. The FMU conducts fiscal site visits for each contracted subrecipient at least once every year. HIV Client Services reviews the FMU's reports for significant issues. If the FMU identifies areas of concern, the subrecipient sends corrective action plans within 60-days of notification. The Department remains in contact with the contractor until issues are satisfactorily resolved.

In addition to the FMU's visits, HIV Client Service staff conducts annual fiscal site visits. For these visits, providers submit supporting documentation for their billings, including timesheets, copies of their general ledger, and receipts of expenses. DOH reviews client level data to verify provision of services. If DOH identifies areas of concern, the contractor must provide documentation of questionable expenses and develop a corrective action plan within 60-days of notification. Fiscal audits monitor compliance with federal allowable cost rules and gauge the amount of technical assistance needed.

DOH requires subrecipients to submit fiscal reports based on their contract budgets, via monthly invoices. Contractors report expenditures by line item. The Contract Coordinator or Fiscal Coordinator reviews each invoice for fiscal accuracy and consistency with reported service units. This review assures that DOH only reimburses for allowable services.

Corrective Action Plans

The Department's Statement of Work boilerplate specifies corrective actions in the event that a breach of contract has occurred. The subrecipient must respond within fourteen days of receipt of notification. The response must be a corrective action plan that includes specific steps the subrecipient will take to address the deficiencies noted and specify a proposed completion date. If a subrecipient fails to respond or does not successfully implement its corrective action plan within the agreed-upon period, the Department may either terminate or suspend the contract.

The Department may terminate a contract for default if the Department has determined the subrecipient has failed to comply with the conditions of the contract. The Department may also terminate a contract if it has a reasonable basis to believe that the contractor has:

- Failed to meet or maintain any requirement for contracting with the Department
- Failed to ensure the health or safety of any client for whom services are being provided
- Failed to perform under, or breached, any term or condition of the contract
- Violated any applicable law or regulation

PLWH Core Medical and Support Services Standards

Service standards outline the elements and expectations a HCS provider follows when implementing a specific service category. The purpose of service standards are to ensure that all service providers offer the same fundamental components of the given service category across Washington State.

Standards provide a direction to the delivery of HIV services. They provide a framework for evaluating services and define the HCS provider's accountability to the public and to the client. Standards of care are minimum requirements that programs are expected to meet when providing HCS.

Format of Core Medical and Supportive Standards

The standards are in the format below. Review the format and refer back to this section if you have questions while reading the standards.

Service Category Definition – Each service category has a brief description of the service category.

Client Characteristics – Each service category has a definition of clients eligible for services.

Unit of Service – Each service category has a "service unit" definition.

Strategies - Each service category has a list of required strategies needed to meet contract deliverables.

Key Services Components and Activities – Each service category has a bulleted list of required Key Services Components and Activities.

Data – Each service category has a list of required data elements.

Standards – Each standard is broken into "Key Services Components and Activities" performed and outlined in a chart format. The chart format includes the Standard, Criteria, and Documentation. The table below shows the chart format. Additional narrative detail may accompany the Standard.

The Standards establish the minimum requirements that programs must follow. Providers may exceed these standards.

Standard	Criteria	Documentation
Minimum requirement that DOH expects programs to meet when providing services.	Specific activities required to meet the standard.	Appropriate documentation required.

Case Management

Service Category Definition

Case management is a formal and professional service that links clients with chronic conditions and multiple service needs to a continuum of health and social service systems. Case management strives to ensure that clients with complex needs receive timely coordinated services, which assist a client's ability to function independently. Case management assesses the needs of the client, their support system, including family and others, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the client's needs.

Washington's statewide standards for HIV case management apply to programs providing Title XIX Targeted HIV Case Management services as well as DOH funded Case Management.

Goals and Objectives

The HIV/AIDS continuum of care is a complex network of medical and social service agencies that can be considerably challenging. Case managers play a vital role in helping clients navigate and access care and resources related to HIV.

Case managers assist clients in addressing barriers while providing services that are flexible and responsive to the client's current medical and social needs. Case management reflects a philosophy that affirms a client's right to privacy, confidentiality, respect, nondiscrimination, dignity, and self-determination.

The goal of case management is to help clients gain and maintain access to primary medical care and treatment. In the process of meeting this goal, case managers must assess and facilitate each client's progress toward autonomy.

The overall objectives of case management are to:
- Gather information to assess and determine each client's needs, as well as related strengths and challenges
- Develop and implement a service plan to build on those strengths and overcome those challenges
- Provide linkage to a continuum of resources and services aimed to assist the client in achieving and maintaining stability across a multitude of life domains
- Promote knowledge and skill building to enhance clients' confidence around navigating their disease and the myriad of intersecting systems
- Assist clients to gain and maintain access and adherence to relevant care and treatment
- Promote viral suppression for the purpose of reducing the transmission of HIV and maximizing the potential health and wellbeing of clients served

Case management promotes and supports autonomy, self-determination, and self-efficacy. As such, the case management process requires the consent and active participation of the client in decision-making, and supports a client's right to privacy, confidentiality, self-determination, dignity, respect,

nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality case management services.

Levels of Case Management

Recognizing changes occurring in the HIV/AIDS epidemic and in the needs of PLWH, DOH uses a four-acuity level approach to case management. DOH groups the four acuity levels (High, Medium, Low, and Preventative Support) into two service tiers: Case Management Engagement and Case Management Retention.

Support services

For those clients receiving support services, such as transportation assistance, food vouchers, or housing assistance in addition to Engagement and Retention Services, the provider must follow the eligibility documentation guidelines under that service category.

Client Characteristics

PLWHA residing in Washington State who could benefit from support, advocacy, resource or benefit referral and linkage, information and education, skill building or coordination of services around their medical or psychosocial needs.

Unit of Service

A service unit for case management is a face-to-face visit (office or community), non-face to face contact (phone, text, email, mail), or collateral contact.

Strategies

- Provide case management services for PLWH in compliance with WA State HIV CM Standards.
- Utilize Acuity Guidelines to ensure delivery of appropriate level of services and related resources.
- Prioritize medical engagement/retention, viral suppression, and stable housing as recognized indicators of positive health outcomes and quality of life.
- Utilize Client Centered Approach.
- Practice Cultural Humility in all aspects of care and service delivery.
- Intentionally track and address Health Disparities for Populations of Interest within your community as related to Case Management Services and outcomes.
- Meaningfully incorporate consumer feedback into program design, implementation, and evaluation.

Key Service Components and Activities

- Eligibility Determination
- Records Management
- Client intake
- Comprehensive assessment
- Acuity assessment
- Individualized service plan

- Service plan implementation
- Case Closure Lost to Care
- Special Populations

Data

Providers must document and be prepared to share with the Department the design, implementation, target areas, populations, and outcomes of Case Management, including:

- Number of PLWH served by county
- Case Management services provided by Date and Type of Service
- Viral Load Values and Dates by Client
- HIV related Medical Engagement Visits by Client
- Housing Arrangement by Client

Eligibility Determination

Purpose

The purpose of this standard is to establish the specific requirements of eligibility for Case Management beyond those articulated in the Universal Standards preceding this section. This includes the elements of eligibility, methods of documentation, timelines of collection and requirements around reassessment of eligibility. For Case Management Services, the client's Acuity Determination influences these.

Eligibility Determination, Initial

An HCS provider must determine and verify initial eligibility for Case Management services, regardless of acuity, through the collection of supporting documentation within thirty (30) days of initiating intake. Eligibility for Case Management includes WA Residency and HIV positive status.

An HCS provider must verify Health Coverage Status within thirty (30) days of initiating intake.

There are no income qualifications on Case Management. An HCS provider does have to collect income information, including Household Income and Household size, for all case managed clients within thirty (30) days of initiating intake.

An HCS provider must complete an Acuity Assessment as part of the initial Intake Process.

Clients are **eligible for Engagement Services** if the HCS provider establishes that their care coordination, support, advocacy, referral and linkage, education or skill building needs related to gaining or maintaining access to and retention in care and treatment are moderate or higher.

Clients are **eligible for Retention Services** if and only if they are:

- Virally suppressed for a minimum of six (6) months[2]
- Well engaged with medical care
- Adherent to their current treatment plan
- Linked to a reliable payer for medical and medication access and treatment
- Without significant life domain vulnerabilities that would suggest a high likelihood of disruption to one of the above

Eligibility Determination, Reassessment

For **Engagement Clients**, an HCS Provider must reassess and verify, through the collection of supporting documentation, both WA residency and health coverage status a minimum of every six (6) months. New copies of acceptable residency and health coverage materials showing current information, or a signature and date by the Client on an existing copy of these documents verifying no change to status are allowable. A current letter of eligibility for EIP will also suffice for reassessment of WA residency and health coverage status.

HCS provider must collect information on household income and size every six (6) months. The provider can obtain this through client attestation. The HCS provider must enter information into the Annual Review tab of CAREWare.

For **Retention** Clients, an HCS Provider must reassess and verify, through the collection of supporting documentation, both WA residency and health coverage status a minimum of every twelve (12) months. New copies of acceptable residency and health coverage materials showing current information, or a signature and date by the Client on an existing copy of these documents verifying no change to status are allowable. A current letter of eligibility for EIP will also suffice for reassessment of WA residency and health coverage status.

The HCS provider must collect information on household income and size every twelve (12) months. This can be collected through client attestation and entered into the Annual Review tab of CAREWare.

Standard

Standard	Criteria	Documentation
Case Management is for PLWH residing in WA State who can benefit from support, advocacy, referral, and linkage to benefit systems and community resources, information and education, skill building or coordination of services around their health condition(s).	HCS provider assesses client need for Case Management.	HCS provider has documentation that client has Case Management Needs.
Engagement Case Management is for PLWH residing in WA State whose care coordination,	HCS provider assesses client acuity at Medium or High.	HCS provider has documentation of client acuity assessment.

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[2] Exceptions to viral suppression for Retention Services include clients not recommended for ART due to their status as elite non-progressors.

support, advocacy, referral and linkage, education or skill building needs related to gaining or maintaining access to and retention in care and treatment are moderate or higher.		
Retention Case Management is for PLWH residing in WA State who have CM needs and meet the following criteria: - Virally suppressed for a minimum of six (6) months[3] - Well engaged with medical care - Adherent to their current treatment plan - Linked to a reliable payer for medical and medication access and treatment - Without significant life domain vulnerabilities that would suggest a high likelihood of disruption to one of the above	HCS provider assesses client acuity as Low.	HCS provider has documentation of client acuity assessment.
Initial Determination of Eligibility for Case Management does not include Income.	HCS provider will provide services to eligible clients regardless of their FPL.	HCS provider collects and documents within CAREware Annual Review Tab information on Client FPL within thirty (30) days of initiating intake
Initial Determination of Eligibility for services will include Washington State residency.	HCS provider will provide services to clients meeting Washington State residency requirements.	HCS provider has documentation of Washington State residency within thirty (30) days of initiating intake.
Initial Determination of Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider collects documentation of HIV status within thirty (30) days of initiating intake.
Initial Determination of Eligibility for services will include assessment of Health Coverage Status.	HCS provider will assist clients to maximize their Health Coverage Status.	HCS provider collects documentation of client's Health Coverage Status within thirty (30) days of initiating intake.
Reassessment for Engagement services will include WA State residency every six (6) months.	HCS provider will verify WA residency every six (6) months.	HCS provider has documentation of Washington State residency

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[3] Exceptions to viral suppression for Retention Services include clients not on ART due to their status as elite non-progressors.

Reassessment for Engagement services will include Health Coverage Status every six (6) months.	HCS provider will verify Health Coverage Status every six (6) months.	HCS provider has documentation of client's Health Coverage Status.
Reassessment for Engagement services will include Household FPL every six (6) months.	HCS provider will collect information on Household FPL every six (6) months.	HCS provider documents Household FPL in CAREWare Annual Review tab every six (6) months.
Reassessment for Retention services will include WA State residency every twelve (12) months.	HCS provider will verify WA residency every six (6) months.	HCS provider has documentation of Washington State residency
Reassessment for Retention services will include Health Coverage Status every twelve (12) months.	HCS provider will verify Health Coverage Status every six (6) months.	HCS provider has documentation of client's Health Coverage Status.
Reassessment for Retention services will include Household FPL every twelve (12) months.	HCS provider will collect information on Household FPL every twelve (12) months.	HCS provider documents Household FPL in CAREWare Annual Review tab every twelve (12) months.

Records Management

Purpose: Providers must manage records appropriately to document case management. Documentation is written proof or evidence of a case management encounter. Client records are legal documents that must be securely stored and securely transferred. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standards

Standard	Criteria	Documentation
Case Management records will reflect compliance with the Case Management Standards of Care. Records must be complete, accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Case Management records include: - Date of client visit or contact - Reason for visit or contact - Activities performed - Outcome - Follow-up Plan - Documentation that client meets eligibility criteria
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider documents Case Management services in case notes with corresponding service units.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness.	Provider is able to report on Performance Indicators and Outcome Measures.

Client Intake

Purpose

The purpose of the client intake standard is to ensure that case management staff collect basic client information, ensure delivery of subrecipient policies and procedures, and enroll clients into services in a timely manner.

Intake - Primary Activities

For each prospective client who requests case management or Title XIX HIV Case Management services, staff must:

- Begin intake process within two (2) weeks of initial contact (this is determined by the date when a client first requests case management services)
- Complete intake process within two (2) weeks of initiating Intake
- Ensure timely outreach to clients referred by third parties.
- Share and ensure understanding of all client related policies and procedures in a timely manner.

Collect sufficient client information to ensure reliable contact and initiation of services

Intake Activity: Third Party Referrals

If another provider refers a client (e.g. another HCS provider assisting with the transition of a client to a new HCS provider; a referral from a medical provider, housing support subrecipient, mental health subrecipient, etc.), case management staff must follow up with the referring provider within 48 business hours. The case manager must check in with the referred client where appropriate permissions and contact information to establish client interest in services and schedule an intake within two (2) weeks of contact.

Special Population Considerations for Third Party Referrals

In the case of certain third party referrals, where the referred client is experiencing a particularly salient episode of vulnerability, best practices suggest an elevated level of care and attention to the engagement process.

DOH calls out two such third party referrals in this Standard: referrals from Disease Investigative Specialists (DIS) and referrals from Department of Corrections (DOC).

For clients referred by either DIS or DOC, it is strongly encouraged that HCS providers prioritize these referrals and make every possible effort to intake these clients at the earliest opportunity, even as far as same day appointments if such would increase the likelihood of engagement by the referred client.

DOH recommends careful and continual follow up with DIS and DOC around referred clients as a way to retain protective factors for clients as long as possible. To this end, DOH recommends securing an Authorization to Exchange Information between DIS or DOC. The intention of these recommendations is to support engagement and retention by referred clients in case management as well as services linked by case management.

Intake Activity: Policies and Procedures

During the intake process, staff will:
- Obtain consent for case management services
- Explain the subrecipient's eligibility policy
- Explain the subrecipient's confidentiality policy
- Explain the subrecipient's client rights and responsibilities policy
- Explain the subrecipient's grievance policy
- Explain subrecipient's reassessment of eligibility policy
- Explain the subrecipient's transition/discharge policy
- Explain client's freedom to choose a provider
- Obtain client signatures on needed ROI form(s)

Case managers or case manager assistors must document that the client received, or staff offered a copy of, and understood, all of the above documents. Documentation can consist of a sentence at the end of the rights and responsibilities policy (e.g. "I acknowledge that I have read and understand these rights and responsibilities and I have been offered a copy of all subrecipient policies. I consent for case management at *blank* subrecipient") which is signed and dated by the client. Alternatively, the subrecipient can create a cover sheet identifying all of the policies and procedures offered, along with a line indicating understanding of said documents and consent to services. Client must sign and date this page.

HCS provider must offer and explain Policies and Procedures within thirty (30) days of initiation of services.

The ROI must include language referencing DOH (and DSHS where applicable (i.e. for those clients receiving Title XIX Targeted HIV Case Management) as one of the entities with whom information may be shared for purposes of monitoring and assessing quality, program, or fiscal compliance.

Intake Activity: Client Information

Case managers or case manager assistors should use the intake process to gather basic contact and demographic information and to identify presenting problem(s). The agency's client intake form must include the following client information:
- Name, address, and phone
- Gender, sex at birth, race, ethnicity
- Preferred method of communication (e.g., phone, email, text or mail)
- Allowable method(s) of communication (e.g. phone, email, mail, text)
- Emergency contact(s) information
- Preferred language of communication

DOH provides a combination Intake/Comprehensive Assessment form for use by our subrecipients. If HCS uses an alternative to this Intake form, DOH must approve it.

If a client is currently on Antiretroviral Therapy (ART) medications, it is imperative to assess the client's needs for access to medications. Case managers or case manager assistors should prioritize helping clients gain or maintain access to medications.

Standards

Standard	Criteria	Documentation
HCS Provider will set Intake in a timely way.	HCS will set intake within two (2) weeks of Client stated interest in establishing services with HCS provider.	HCS provider documents the date of first contact by or with client.
		HCS provider documents the date of Intake appointment.
HCS provider will complete Intake in a timely way.	HCS will complete intake within two (2) weeks of initiation.	HCS provider documents the date intake began and date Intake was completed.
HCS provider will respond to third party referrals in a timely way.	HCS provider will contact both the third party referrer and the referred client if appropriate permissions and contact information is provided within forty-eight (48) business hours from receipt of referral.	HCS provider documents the date they received the referral and the date they acted upon the referral.
HCS provider will effectively communicate all relevant Policies and Procedures to Clients in a timely way.	HCS provider will share and explain the following Policies and Procedures to all clients within thirty (30) days of initiation of services : - Obtain consent for case management services - Explain the subrecipient's eligibility policy - Explain the subrecipient's confidentiality policy - Explain the subrecipient's client rights and responsibilities policy - Explain the subrecipient's grievance policy - Explain subrecipient's reassessment of eligibility policy - Explain the subrecipient's transition/discharge policy - Explain client's freedom to choose a provider	HCS provider documents that client received and understood all relevant Policies and Procedures.
		Documentation includes date and signature by Client attesting to both receipt and comprehension of Policies and Procedures.
		Date on attestation is within thirty (30) days of initiation of services.

HCS provider will obtain all necessary permissions for the sharing of client information.	HCS provider will complete a Release of Information with Client that includes all persons or entities client approves HCS provider to share information with for the purpose of treatment planning, coordination of services, or progress toward/resolution of client identified goals.	Signed and dated ROI in client file articulating all persons or entities client approves HCS provider to share information for treatment planning, coordination of services, or progress toward/resolution of client identified goals.
	The ROI must include language identifying DOH (and DSHS where applicable) as one of the entities with whom information may be shared for purposes of monitoring and assessing quality, program, or fiscal compliance.	The ROI includes language identifying DOH (and DSHS where applicable) as one of the entities with whom information may be shared for purposes of monitoring and assessing quality, program, or fiscal compliance.
HCS provider will obtain permission from DOH to use any Intake document other than the combination Intake/CA form provided by WA DOH.	HCS will obtain permission from DOH for use of an alternative Intake form.	HCS documents that DOH approved alternative Intake form.

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Comprehensive Assessment
Purpose

The purpose of the Comprehensive Assessment (CA) standard is to ensure that case managers complete the CA in a timely manner; complete reassessments at appropriate and regular intervals; and gather historical information and current symptoms/life domain status to determine clients' needs across life domains.

The intention of a CA is to gather relevant information around the client's immediate needs as well as projected barriers to client-centered services that will facilitate the creation of an Individual Service Plan (ISP). The CA is a cooperative and interactive activity between the case manager and the client. The client is the primary source of information. However, with client consent, assessments may include additional information from medical or psychosocial providers, caregivers, family members, and other sources of information. The case manager is encouraged to contact other service providers/care givers involved with the client or family system in support of the client's wellbeing. Case managers must comply with established subrecipient confidentiality policies when engaging in information collection and coordination activities.

Case management agencies must use the Washington State Department of Health's comprehensive assessment unless the HIV Client Services Community Programs Supervisor or the Statewide Case Management Coordinator grants a waiver. The Washington State Department of Health worked extensively with case managers throughout Washington State to create our CA. This CA satisfies the requirements noted in case management standards as well as the WAC for *Case Management for persons living with HIV/AIDS* (WAC 388-539-0300 and 0350).

The case manager must sign and date the completed assessment. Agencies using electronic medical records may use electronic signatures.

CA Timeline
Case managers must begin and complete a CA within the following timeframe:
- A Comprehensive Assessment must be completed within 30 days of completing intake
- A Comprehensive Reassessment must be completed for Engagement Clients at minimum every 5 years; there is no regularly reoccurring requirement for Comprehensive Reassessment for Retention clients
- Completion of a Comprehensive Reassessment if there is a significant (more than 50%) change in life domain stability/activity

Comprehensive Assessment
It is essential to capture information about a client's medical history as well as current symptoms and status. Gathering general medical history and currency is important, as are the specifics of their HIV disease status and history of opportunistic illnesses. Assessing the client's experience with medication adherence is also important. Case managers should additionally assess for co-occurring physical health

problems such as TB, hepatitis, or sexually transmitted infections. Case managers must assess the client's history and current needs in these areas:

- Primary medical care
- Oral health care
- Medical nutrition services
- Medication/Adherence
- Home health care
- Entitlement program benefits such as Medicare, Medicaid, Veteran's Administration
- HIV health access benefit services: HIV Early Intervention Program (EIP), Evergreen Health Insurance Program (EHIP)
- Mental health services
- Substance abuse treatment
- Physical mobility/activities of daily living
- Housing
- Social/emotional support
- Employment/re-employment
- Medical transportation
- Legal
    - o HIV-related
    - o Justice Involvement
    - o Immigration
- Linguistic services
- Knowledge of HIV disease
- Knowledge of prevention/transmission of HIV and STI
- Tobacco use
- Sexual and Reproductive Health
- Affected family/household members
- Food insecurity/meal programs

Standards

Standard	Criteria	Documentation
HCS provider works collaboratively with the client and appropriate third parties to conduct a confidential assessment of client's history as it relates to their HIV disease as well as immediate needs.	Provider conducts a comprehensive assessment with the client and appropriate third parties.	The client record documents a completed assessment form covering the following: - Medical - Mental health - Substance use - Psychosocial needs - HIV risk behaviors - Food - Housing - Insurance - Self-Efficacy - Legal - Adherence

		- Employment/Financial - Cultural/Linguistic - Prevention/Education
HCS staff completes the CA in a timely manner.	HCS provider completes CA within thirty (30) days of completion of intake.	HCS provider completed CA.
HCS staff competing the CA will sign and date the document.	HCS staff signs and dates completed CA.	HCS staff signature and date on CA.
HCS staff completes Comprehensive Reassessments every five (5) years with Engagement clients.	HCS staff reassesses Engagement client at regular intervals.	HSC provider documents completed Comprehensive Reassessment at appropriate intervals.
HCS staff completes Comprehensive Reassessments at 50% change in life domain status/activity for all clients.	HCS staff reassesses clients when significant changes across life domains occur.	HSC provider documents when they completed Comprehensive Reassessment.

Acuity

Purpose

The purpose of this standard is to ensure the most efficient and appropriate application of resources across the continuum of clients accessing case management through the creation and articulation of service tiers and acuity levels, the establishment of methods and timelines for assessing acuity along with corresponding service and documentation expectations.

Acuity is the intensity or severity of condition or service need. Acuity can be from a client or patient perspective, a provider perspective or a systems perspective. DOH takes a combination approach to acuity, considering the severity, intensity or duration of client conditions and needs against the backdrop of overall resource availability and access, as well as the relative health of the systems in which clients are residing and services are transpiring. Woven into these determinations is an attempt to consider client ability or capacity to overcome barriers or deficits to said systems and to navigate successfully through. An HCS provider evaluates a client's sense of empowerment to determine the likelihood that the clients will activate themselves to overcome those same barriers or deficits.

Washington State uses an acuity model in case management for the following reasons:
- To create better opportunities for better fits and better outcomes, i.e. "The "right" service at the "right" time by the "right" person at the "right" dose"
- Diversification of staff requirements and therefore diversification of staff expertise
- Maximizing resources while maximizing impact
- Creating a better fit between client need and documentation requirements

WA DOH uses a four-acuity level approach to case management. DOH groups the four acuity levels (High, Medium, Low, and Preventative Support) into two service tiers: Case Management Engagement and Case Management Retention.

Case Management Engagement

Case management engagement is the proactive engagement on a monthly or bi-monthly basis at minimum for continued assessment of medical engagement, adherence to recommended medical care and regimens, life domain needs and provision of necessary and appropriate coordination of care and referrals to support services.

Level 1: High Acuity Clients

High acuity clients have multiple chronic issues that have a synergistic negative effect on health outcomes, or have severe and acute issues requiring short-term crisis intervention. These clients will often require a high level of coordination with medical providers and other key health team members around engagement in medical care and treatment and other related supportive services.

Service expectation with or on behalf of High Acuity Clients is monthly.

Level 2: Medium Acuity Clients

Medium acuity clients need moderate assistance in coordinating care and/or support services in order to gain and maintain access to and retention of care services as well as treatment adherence.

Service expectation with or on behalf of Medium Acuity Clients is bi-monthly (every other month).

Case Management Retention

Case management retention is for PLWH who require minimum check in from case management providers to sustain their care, such as quarterly telephonic contact to ascertain continued adherence to medical care and regimens and life domain stability. To be eligible for Retention Services, a client must be virally suppressed, insured, well engaged in care and have achieved general life domain stability

Level 3: Low Acuity Clients

Low acuity clients need minimal assistance to maintain adherence to recommended medical care, treatment regimens, and life domain stability.

Service expectation with or on behalf of Low Acuity Clients is quarterly (every three months).

Level 4: Preventative Support Services

Client has stable life domains and do not need additional support to adhere to medical care and treatment regimens. The intention of Preventative Support Services is to provide an easy access point back into higher acuity services if changes to life domains occur that present new barriers or challenges to care and treatment access.

Service expectation with or on behalf of Preventative Support Clients is triannually (every four months).

Assessment of Acuity

The HCS provider assesses acuity along with the Comprehensive Assessment for all clients entering services.

Reassessment of acuity should take place at minimum every six (6) months for Engagement clients and every twelve (12) months for Retention clients.

DOH does not recommend reassessment of acuity more frequently than every three (3) months.

Acuity Guidelines

DOH uses an Acuity Guidelines worksheet to help determine acuity. These guidelines were developed with the DOH case management community and reflect historical or current life domain statuses that commonly reflect heightened vulnerabilities to loss of access to care or treatment, as well as greater needs for support, advocacy, resources, coordination, navigation, education, or skill building to gain or maintain access to treatment and care.

Tracking Acuity

DOH requires HCS providers track services provided to clients within case management or other support services in CAREWare. For each of those service entries, HCS provider staff must delineate the service tier assigned to that client – either Engagement or Retention.

Providers must identify acuity by service tier (High vs Medium or Low vs Preventative Support Services) on the CA, ISP as well as in the Universal CM Custom tab.

PLWH Acuity Guidelines

Review ALL levels of Intensity below, select boxes that best reflect client's current situation. Enroll client in appropriate level of engagement or retention in care services.

Engagement Services = Proactive engagement on monthly basis at minimum for continued assessment of medical engagement, adherence to recommended medical care and regimens, life domain needs and provision of necessary and appropriate coordination of care and referrals to support services.

Level 1: High Acuity Clients

Clients with multiple chronic issues that have a synergistic negative effect on health outcomes or clients with severe and acute issues requiring short-term crisis intervention. These clients often require a high level of coordination with medical provider(s) and other key health team members around engagement in medical care and treatment and other related supportive services.

Automatic Categorization as High Acuity Client:	**Additional Considerations for Categorization as High Acuity Client:**
☐ Newly Diagnosed (w/in 6 months)	☐ Not adherent to HIV medical appointments
☐ Detectable Viral Load	☐ Pregnant
☐ Not in HIV care	☐ No access to ARV's
☐ Not on ARV's (if recommended)	☐ Medical emergency/hospitalization
☐ Not adherent to ARV's	☐ Current IDU
☐ Homeless	☐ Other medical conditions not addressed(i.e. Hepatitis C, diabetes)
☐ Justice Involved in past 12 months	☐ Meets criteria for population of interest related to Health Disparities (US and Foreign Born Black, Foreign Born Hispanic, aged 45 or older)

Level 2: Medium Acuity Clients

Clients needing moderate assistance in coordinating care and/or support services

Considerations for Categorization as Moderate Acuity Client:	
☐ Isolation	☐ Linguistic challenges
☐ No insurance or incomplete or insufficient coverage	☐ Legal issues impeding other areas of life
☐ Unstable housing	☐ Transportation needs
☐ Current domestic violence and/or abuse	☐ Income insufficient to meet needs
☐ Unmet or unaddressed Mental health needs	☐ Needs frequent assistance navigating systems
☐ Current or historical substance abuse	☐ No stable support network
☐ Financial needs identified (i.e. utility assistance, HOPWA, etc.)	☐ Post incarcerated re-entering
	☐ Meets criteria for population of interest related to Health Disparities (US and Foreign Born Black, Foreign Born Hispanic, aged 45 or older)

Retention Services= Minimum of quarterly telephonic contact to ascertain continued adherence to medical care and regimens and life domain stability.

Level 3: Low Acuity Clients

Clients needing minimal assistance in order to maintain adherence to recommended medical care, treatment regimens, and life domain stability.

Minimum requirements:	**Life Domain Strengths to Look For:**
☐ Current viral suppression maintained for minimum of 6 months	☐ Reliable access to transportation
☐ Adherent to HIV medical appointments	☐ Steady, sufficient source of income
☐ Enrolled in comprehensive coverage	☐ No unmet mental health needs
☐ Without significant vulnerabilities in regard life domain stability	☐ No current Substance Abuse

Level 4: Preventative Support Clients

Clients with stable life domains who do not need additional support to adhere to medical care and treatment regimens.

☐ Meets all the criteria of Low Acuity; historically would fall into the category of clients recommended for closure or graduation from CM services.

☐ Willing to accept ongoing telephonic check ins on a minimum quarterly basis to provide preventative support in case of change in circumstances or referral need.

Service and Documentation Expectations by Level

Level 1 High Acuity Clients

- Reassess Eligibility for services every six months, inclusive of Acuity Assessment.
- Reassess ISP at minimum every six months.
- Providers must complete a Comprehensive Assessment every five years from initial entry into case management
- Providers must provide a minimum of one activity per month with or on behalf of the client in effort to move identified goals forward. The expectation for high acuity clients includes very regular contact with client as well as frequent contact with, and coordination of, a larger support team

Level 2 Medium Acuity Clients

- Reassess Eligibility for services every six months, inclusive of Acuity Assessment
- Reassess ISP at minimum every six months
- Providers must complete a Comprehensive Assessment every five years from initial entry into case management
- Providers must provide a minimum of one activity bi-monthly (every other month) with or on behalf of the client in effort to move identified goals forward

Level 3 Low Acuity Clients

- Reassess eligibility for services annually, inclusive of Acuity Assessment
- Reassess ISP a minimum of every twelve months. DOH will accept non-traditional ISP formats, such as life domain checklists.
- Providers must provide a minimum of one activity per quarter with or on behalf of the client to continue life domain stability, continuity of medical engagement, and continued viral suppression

Level 4 Preventative Support Clients

- Collection of eligibility documents at initial entry into this service level only
- Reassessment of eligibility annually via client attestation allowed
- No ISP required
- Providers must provide a minimum of one activity triannually (every four months) with or on behalf of the client to assess life domain stability, continuity of medical engagement, and continued viral suppression

Case Management Standards – Individualized Service Plan

Individualized Service Plan

Purpose

The purpose of the Individualized Service Plan (ISP) standard is to ensure that case management staff create an ISP that is client-centered and client-voiced; complete the ISP in a timely manner; link the ISP to the CA; and develop an action plan that meet's client's needs and goals.

Timeline

 Case management staff must:
- Complete and sign ISP within 2 weeks of completing the CA
- Reassess ISP for Engagement Clients every six (6) months at minimum
- Reassess ISP for Retention Clients every twelve (12) months at minimum

ISP – Primary Activities

Goals and Action Steps

Following   the comprehensive assessment, the case management staff assists the client in developing their ISP. The ISP is a set of goals meaningful to the client and relevant to gaining or sustaining viral suppression, medical engagement, and improved health outcomes paired with activities or action steps intended to assist the client in achieving those goals. The ISP aims to help clients move towards maximizing self-agency and sufficiency.

Signatures and Documentation

The ISP is a client-centered and client-owned document. As such, both the case management staff and the Client must approve the initial ISP and all subsequent changes to the ISP. To do so, the client and case management staff must sign and date the document.

HCS providers can make updates to the ISP without client signature. In such cases, the following must occur:
- Case manager must discuss changes with the client
- Changes must be generated by the client or at minimum approved by client
- A note must be made by case management staff both on the ISP and in the client chart attesting to said discussion and approval
- Case manager must offer a copy of the ISP to the client upon its creation and with every update and document that they made the offer

Link to Assessment

The ISP must include service goals and activities that specifically link to the client's needs identified during the initial comprehensive assessment and subsequent reassessments.

ISP Content

Case managers must develop an ISP that addresses:

- Client goal(s) toward improved health outcomes related to HIV
- Client needs or gaps in services and barriers to access or achieving stated goal(s)
- Action steps to address needs/gaps in services and barriers to access, including referrals to third party services, benefits or resources
- Person responsible for action steps in ISP
- A method to measure success

Reassessment

Reassessing a client allows the case manager to identify new issues and needs as well as evaluating the client's strengths and progress towards self-sufficiency. Case managers use this information to update the ISP and establish new goals. Case managers must do an interim reassessment utilizing the ISP every six (6) months for Engagement clients and every twelve (12) months for Retention clients.

Retention Clients

DOH will accept non-traditional forms of service planning for Retention clients. These may take the form of a life domain checklist, a series of targeted HIV case management outcomes-based questions (e.g. "Are you experiencing any barriers to accessing medications?), or other reliable form of assessing ongoing stability of viral suppression, access, and engagement to treatment and care.

Standards

Standard	Criteria	Documentation
HCS provider develops, uses, and reassesses the ISP jointly with the client.	The service plan is a plan of action designed by both case manager and client as a means to help the client achieve their stated goals.	There is documentation in client chart of ISP that includes: - client initiated goal & action steps - persons responsible, measurements of success - signed and dated by both Client and HCS staff.
	Client and Case manager jointly identify and prioritize problems, goals, and tasks.	
ISP links to the Comprehensive Assessment.	HCS provider will utilize the CA to inform and direct the goals and actions steps identified on the ISP as well as use the ISP to address barriers to care, service needs and gaps identified on the CA.	There is documentation in client chart of ISP elements that link to CA.
HCS provider will complete the initial ISP in a timely manner.	HCS provider will complete the ISP with client within two (2) weeks of completing the CA.	There is documentation in chart of ISP with date completed.
HCS provider regularly updates ISP with client.	HCS provider updates ISP as clinically appropriate or at minimum every six (6) months for Engagement clients.	There is documentation in client chart of updates to service plan.

Case Management Standards – Individualized Service Plan

	HCS provider updates ISP as clinically appropriate or at minimum every twelve (12) months for Retention clients	

Service Plan Implementation

Purpose

The purpose of the standard for service plan implementation is to ensure that case managers complete progress notes in timely and accurate ways; coordinate care with collaborative partners; and ensure achievement and maintenance of desired HIV related health outcomes. Service plan implementation is an on-going process that ensures services are consistent with the agreed upon plan and that clients in case management are making progress on accessing services to meet their needs and goals.

Case Notes

Case notes ensure the most up to date information is available in the client's file and provide documentation that the case manager has followed proper procedures, rules, regulations, and necessary guidelines when providing services. By documenting each contact with or on behalf of a client, case managers are able to track what services the client has received and what services the client still needs to access. The HCS provider must document in the case note the reason for the case manager's interaction with the client and what services they provided. If billing Title XIX, case managers must complete a case note within every billing cycle.

In completing case notes, case management staff must follow these guidelines:
- Document chronologically
- Be entered into CAREWare within five (5) business days of date of service
- Incorporate the goals of the ISP, as well as areas of need, gaps and barriers identified in the CA and carried forward in the ISP
- Provide relevant details of the interaction being memorialized:
    o Reason for interaction with client
    o Person(s) involved in the interaction
    o Client needs and action(s) of the case manager (or others) to address these needs
    o Plan for follow up
- Ensure documentation is clear
    o Proper spelling and grammar are appreciated
    o Write in the third person (e.g. "case manager met with client and discussed options for medication coverage")
    o When necessary, append notes as appropriate
- Be objective in documentation
- Record all interactions with and on behalf of client
- Complete, "sign" and date within 5 business days of encounter or visit with, or on behalf of, the client
    o In CAREWare, a signed Case Note includes, at minimum, the initials, and title of the note creator at the end of each note. Credentials can be included if desired.
    o If Authorship is available, select the appropriate Case Note author as well.

Case Management Standards – Service Plan Implementation

| Comprehensive Assessment | Service Plan | Implementation/Case Notes | Reassessment |

Coordination of Services

A critical role of the case manager is the coordination of communication and services within a clinic, subrecipient, or care system. Care coordination includes case conferences, access to client records, or the use of written communication to indicate a client's utilization of services.

Case managers must ensure the coordination of services by:
- Identifying staff or service providers with whom the client may be working
- Acting as a liaison between clients, caregivers, and other service providers to obtain and share information that supports optimal care and service provision
- Facilitating the scheduling of appointments, transportation, or transfer of information when a client is unable to do so him or herself
- Assisting clients to increase navigation and communication skills, system knowledge and confidence so that clients can independently:
    o Navigate the care system
    o Communicate directly with providers
    o Schedule appointments
- Maintaining access to and payment of medical services through health care coverage

Treatment Adherence

Among the most important goals of case management is for the case manager to:
- Coordinate and support HIV related medical treatment, engagement, and retention
- Provide support for ART treatment adherence

Case managers have a responsibility to directly provide or link their clients on ART to treatment adherence services. An assessment of adherence education and support needs begins as soon as a client enters case management and continues as long as a client remains in case management. Treatment adherence support is an on-going process that changes as the client's needs, goals, and medical condition change. The goal of any treatment adherence intervention is to provide a client with necessary skills, information, and support to follow mutually agreed upon and evidence-based recommendations of healthcare professionals to achieve optimal health.

Prevention

Purpose

The purpose of this standard is to establish the importance and regularity of assessment, referral, linkage, or provision of HIV and STI related prevention activities to PLWH engaged in HIV case management.

Case managers have ongoing relationships with clients whose HIV and sexually transmitted infections (STI) prevention needs vary throughout the course of their lives. Evidence-based HIV or STI prevention services help clients protect themselves and others in high-risk situations and environments. HIV or STI prevention services should be coordinated with HIV care services to help clients reduce their risk of transmitting HIV, STI or blood borne diseases. This also helps clients reduce their risk of acquiring resistant strains of HIV, STI, or blood borne diseases.

Prevention – Primary Activities

Case management staff must regularly provide accurate information about HIV/STI transmission risks and promote evidence-based HIV or STI prevention activities. Provider must document this discussion either in a progress note or on the effected ISP.

During the initial assessment and all reassessments, case managers must assess a client's HIV or STI transmission risk. Client needs identified during this process allow case management staff, as appropriate, to:
- Explore clients' readiness to engage with available HIV/STI prevention resources, as necessary
- Refer clients to available HIV/STI prevention and treatment services
- Assist clients to coordinate their participation in HIV/STI prevention services with their medical care
- Assist clients to obtain medical and social support services that reinforce their efforts to reduce HIV/STI transmission
- Document clients' progress toward achieving their acknowledged HIV/STI prevention needs

Case Closure

Purpose

The purpose of this standard is to ensure that case managers use a systematic process to transition or discharge clients from case management services in order to maximize opportunities to preserve continuity of care.

An HCS provider may close a case for any of the following reasons:
- Transition to another HCS provider for case management services = Complete Transition Steps and Summary
- Transition to a more appropriate acuity program = Complete Transition Steps and Summary
- Violation of subrecipient policies and procedures = Complete Discharge Steps and Summary or Transition Steps and Summary, dependent on whether an appropriate alternative provider can be identified
- Client request = Complete Discharge Steps and Summary
- Relocation out of state without transition = Complete Discharge Steps and Summary
- Client Death = Complete Discharge Steps and Summary
- Long term incarceration = Complete Special Population Transition Steps and Summary
- Lost to Care = Complete Lost to Care Steps and Summary (See Lost to Care Standard)

Transition Steps and Summary

Transitioning of clients suggests the active collaboration between client and HCS provider staff. Case management staff in these instances must work with the client to establish the best next steps to receive the continued care and support necessary to maintain and build upon the progress achieved during their time in case management with the current HCS provider. The HCS provider should obtain a ROI that allows for the sharing of information critical to achieving continuity of care.

The HCS provider must document the reason(s) for transitioning a client from case management services in a "Transition Summary". Case managers can accomplish this by using either a subrecipient-generated form stored in the client file or document directly in a CAREWare case note.

A Transition Summary must include the following elements:
- Date of last successful contact with client
- Most recent Acuity level of client
- Most recent VL Date and Value of client
- Reason for Transition (e.g. change in acuity and therefore change in HCS provider program, relocation, complaint with subrecipient, violation of subrecipient policies and procedures with identification of an appropriate transfer subrecipient or program, or other)
- Name and contact information of Subrecipient (i.e. Receiving Subrecipient) or program to which client is transitioning
- Date of first intake/appointment with Receiving Subrecipient or program
- Confirmation that a current ROI is in place with the Receiving Subrecipient

- List of any outstanding ISP goals or activities at time of transition

If the client is transitioning due to a complaint with the current HCS provider, the HCS provider must refer them to the grievance procedure.

Some communication should occur between the HCS provider and the transitioning client articulating lowest barrier method(s) available for reestablishing care in the future with said provider.

Discharge Steps and Summary

Discharging of clients outside special populations considerations, including long-term incarceration, or lost to care, suggests an active collaboration between HCS provider and client. The HCS provider, where appropriate, should make every effort to maximize client well-being and continuity of care.

Case managers must document the reason(s) for discharging a client from case management services in a "Discharge Summary". Case managers can accomplish this by using either a subrecipient-generated form stored in the client file or document directly in a CAREWare case note.

At minimum, a Discharge Summary should include the following elements:
- Date of last successful contact with client
- Most recent Acuity level of client
- Most recent VL Date and Value of client
- Reason for Discharge (e.g. client opting out of case management either locally or following anticipated relocation, violation of subrecipient policies or procedures without identification of an appropriate Receiving Subrecipient, client death, or other)

If the client does not agree with the reason for discharge, the HCS provider must refer them to the provider subrecipient's grievance procedure.

Some communication should occur between the HCS provider and the transitioning client articulating lowest barrier method(s) available for reestablishing care in the future with said provider.

Special Population Transition Steps and Summary
For clients entering into long-term incarceration, HCS providers must make special considerations around ensuring continuity of care. Justice-involved population is particularly vulnerable to losing access to services, care, and treatment.

At minimum, a Special Population Transition Summary should include:
- Date of last successful contact with client
- Most recent Acuity level of client
- Most recent VL Date and Value of client
- Date of outreach to jail services and DOC where appropriate
- Name and contact information of jail services or DOC personnel contacted

Case Management Standards –Case Closure

- Expected date of release
- Confirmation that a current ROI is in place with jail services or DOC
- Confirmation that a plan around medications is in place with jail services or DOC
- List of any outstanding ISP goals or activities at time of discharge

Reason for Closure	Type of Service	Type of Summary	CAREWare Enrollment Status
Transition to another provider/program	Transition	Transition	Referral/Discharge
Violation of subrecipient policies and procedures with transition	Transition	Transition	Removed
Violation of subrecipient policies and procedures without transition	Discharge	Discharge	Removed
Relocation without transition	Discharge	Discharge	Relocated
Death	Discharge	Discharge	Referral/Discharge
Long term incarceration	Special Population Transition	Special Population Transition	Incarceration
Lost to Care Retention	Lost to Care	Discharge	Referral/Discharge
Lost to Care Engagement suspected in care	Lost to Care	Discharge	Referral/Discharge
Lost to Care Engagement suspected not in care	Lost to Care	Lost to Care	Referral/Discharge

Standards

Standard	Criteria	Documentation
HCS provider will take every opportunity to maximize continuity of care.	HCS provider will complete Transition or Discharge steps and summary with every client closed to services.	HCS provider documents Transition or Discharge steps and summary in client chart.
HCS provider will provide lowest barrier method(s) available to reestablishing clients in the future.	HCS provider will communicate methods of reestablishing care in future with client.	HCS provider documents they made client aware of how they may reestablish with HCS provider in future for case management services.

Lost-to-Care
Purpose
The purpose of this standard is to ensure HCS providers understand and pursue all recommended avenues to retain or reengage clients in care and to establish a process for such pursuit that articulates both steps toward reengagement as well as case closure.

When considering clients who are not participating in care, disengaging or fully disengaged, a tiered response by HCS providers should be implemented that complements our acuity model of care. DOH asks that HCS providers begin outreach and reengagement as early as the month following the first identified "unsuccessful" month of expected proactive case management. For high acuity clients, this would mean the second month of no contact (i.e. no contact in March? Begin outreach and reengagement in April). For medium acuity clients, this would mean the third month without successful contact (i.e. no contact in February or March? Begin outreach and reengagement in April). For low acuity clients, this would mean the fourth month without successful contact (i.e. no contact in January, February, or March? Begin outreach and reengagement in April). For Preventative Support Clients, this could mean the fifth month without successful contact (i.e., no contact between January, February, March, or April? Begin outreach and reengagement in May.)

Acuity Tier	Expected Contact Regularity	Begin Outreach Efforts
High	Monthly	Second month of no contact
Medium	Bi-Monthly	Third month of no contact
Low	Quarterly	Fourth month of no contact
Preventative Support	Triannually	Fifth month of no contact

DOH asks that outreach and reengagement attempts exhaust all allowable (i.e. prover has permission from client and, where necessary, a current ROI) methods of contact. This could include telephone, email, text, mail, and possibly in person outreach. It should also include outreach to emergency contacts and collaborative professionals, such as medical providers, pharmacies, housing programs, and so forth where appropriate.

Retention Clients:
There may be instances when an HCS provider has made reasonable attempts to contact and reengage a Low Acuity or Preventative Support client (Retention). If the client's current medical information indicates ongoing engagement in medical care and viral suppression, then the provider should send a letter alerting the Client that the provider will close their file. In the letter, the HCS provider should offer the client the lowest barrier method to restarting services if needed. For clients who the provider closed for fewer than six months, DOH will not require a new intake or Comprehensive Assessment.

The HCS provider must complete a Discharge Summary. A discharge summary can be a subrecipient generated form that is stored in the client chart or as a CAREWare case note. The summary must include:
- Date of last successful contact with client
- Most recent Acuity level of client

- Most recent VL Date and Value of client
- Reason for Discharge (e.g. disengagement from case management without known significant vulnerabilities)

Engagement Clients:

For Medium or High Acuity Clients, DOH requests HCS providers that they alert DOH to the possibility of a "Lost to Care" Client after they have made reasonable attempts at contact and reengage the client. The provider can do this by contacting the Quality Improvement Coordinator at DOH, and offering the name, gender, and date of birth of your client. This position will research the client in all accessible systems in order to discern if there is an alternative contact number and to check most recent lab dates. If this position is unable to identify whether the client is currently engaged in care, they will pass the name to our LOOC (Lost or Out of Care) Coordinator for further investigation. If the client appears truly out of care, DIS will initiate an investigation.

For clients engaged in this DOH Lost to Care process, DOH asks that the client remain "open and active" within the HCS provider system. Providers can continue their own attempts at ongoing outreach and reengagement using what resources they have available. DOH asks that HCS providers communicate any progress.

To identify all clients in a system involved in the Lost-to-Care process, DOH recommends that HCS providers use a "Lost to Care" label in CAREWare. Providers can find this label in the CM Universal Custom Tab under "Case Manager".

Lost to Care Process Complete and Client Reengaged:

If the Lost-to-Care process results in reengagement of the client in care, the provider should continue providing services per Standards. DOH recommends a reassessment of acuity and ISP.

Lost to Care Process Complete and Client **not** deemed "out of care":

If DOH completes the Los-to-Care process and the client is engaged in appropriate medical care and virally suppressed, the HCS provider should send a letter to the Client. In the letter, the HCS provider should alert the client that the provider is closing their file. The HCS provider should offer the lowest barrier method for reengagement available to resume services in the future. The provider must complete a Lost to Care Summary. For clients who the provider closed for fewer than six months, DOH will not require a new intake or Comprehensive Assessment.

The HCS provider must complete a Discharge Summary. A discharge summary can be a subrecipient generated form that is stored in the client chart or as a CAREWare case note. The summary must include:

- Date of last successful contact with client
- Most recent Acuity level of client
- Most recent VL Date and Value of client

- Reason for Discharge (e.g. disengagement from case management without known significant vulnerabilities)

Lost to Care Process Complete and Client deemed "out of care":
If the HCS provider and DOH have completed the Lost to Care processes without success, the HCS provider can send a letter to the Client to alert them that the provider will close their file. The letter should offer the lowest barrier method for reengagement available to resume services in the future. The provider should complete a Lost-to-Care Summary. For clients closed fewer than six months, DOH will not require a new intake or Comprehensive Assessment.

The HCS provider must complete a Lost-to-Care Summary. A Lost-to-Care summary can be a subrecipient generated form or as a CAREWare case note. Lost-to-Care Summary must include the following:
- Date of last successful contact with client
- Most recent Acuity level of client
- Most recent VL Date and Value of client
- Reason for Discharge (e.g. disengagement from case management with known vulnerabilities)
- Date of outreach to DOH
- Date of final feedback from DOH

DOH has added a custom field to CAREWare called "Transition Status". Please choose "Engagement Acuity Lost to Care".

Early Intervention Services

Early Intervention Services (EIS) support early detection and treatment of HIV, to help prevent or delay the onset of opportunistic infections and AIDS.

Service Category Definition

The elements of EIS often overlap with other service category descriptions. However, EIS are the combination of such services rather than a stand-alone service. EIS must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-Infected
  - o HCS providers must coordinate testing services with other HIV prevention and testing services to avoid duplication of efforts
  - o HIV testing paid by EIS cannot supplant testing efforts paid by other sources
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Case Management, and Substance Abuse Care
- Outreach Services and Health Education and Risk Reduction (HE/RR) related to HIV diagnosis

EIS has three subcategories: HIV Testing and Counseling, Linkage to Care, and Retention in Care. Not all providers of Linkage to Care must provide HIV Testing and Counseling, nor must all providers of HIV Counseling and Testing provide Linkage to Care. However, providers must seamlessly link these types of services if provided by separate agencies. All service provision will comply with the HIV Care and Treatment Standards of Care for HIV Testing and Counseling.

HIV Testing and Counseling is an individualized intervention by which clients learn their HIV serostatus and, when testing positive, receive Linkage to Care, risk reduction counseling, and referral to additional services.

Linkage to Care assists PLWH to access appropriate medical care and other services as needed. This assistance will continue until PLWH effectively connect to care. A successful linkage to medical care is an ongoing process during which the client comes to assimilate his or her diagnosis, to understand the implications of an HIV diagnosis for self and others, to opt for appropriate care and services, and to commit to a regimen that enhances one's own health and protects that of others.

Referral must be appropriate to client situation and need. The referral process must include timely follow-up of all referrals to ensure that PLWH actually receives the services. Providers must consider the referral subrecipient as part of the referral process. The HCS provider must ensure clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their referral plan.

Client Characteristics

EIS services are for persons who are unaware of their HIV status or who know their status and are out of care. EIS helps the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected.

Unit of Service

A service unit for EIS is a face-to-face visit (office or community), non-face to face encounter (phone, text, email, mail), or collateral contact.

Strategies

- Provider will provide HIV testing and referral activities to persons at high risk for HIV, with special attention to populations demonstrating health disparities.
- Provider will refer HIV positive persons to HIV care and treatment services.
- Provider will verify linkage of PLWH to HIV care and treatment services.
- Provider will provide outreach services to persons at high risk.
- Provider will provide HE/RR services to appropriate to clients HIV diagnosis, which includes referring PAHR to PrEP services.

Key Service Components and Activities

- Eligibility
- EIS plan
- Service coordination
- Referrals to appropriate services/providers
- Linkage to appropriate services/providers
- Staff qualifications
- Records management

Data

Providers must document and be prepared to share with DOH, the design, implementation, target areas, populations, and outcomes of EIS, including:

- Number of persons at high risk outreached
- Number of persons at high risk provided HIV test
- Number of persons at high risk provided health education and risk reduction services
- Number of individuals who become aware of their HIV status
- Number of referrals to case management
- Number of referrals to medical care
- Number of HIV-positive individuals linked to case management
- Number of HIV-positive individuals who are linked to medical care
- Number of HIV-negative individuals referred to services that contribute to keeping them HIV-negative

Standards

Eligibility

Purpose: Providers of EIS will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
EIS are for persons who are unaware of their HIV status or are positive and out of care.	HCS provider assesses client need for EIS.	HCS provider has documentation that client needs Early Intervention Status.
Initial Determination of Eligibility for Case Management does not include Income.	HCS provider will provide services to eligible clients regardless of their FPL.	HCS provider collects and documents within CAREware Annual Review Tab information on Client FPL within thirty (30) days of initiating intake.
For persons who are unaware of their HIV status or who know their status and are out of care, eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
For persons who are unaware of their HIV status or who know their status and are out of care eligibility for services will include Washington State residency.	HCS provider will provide services to clients meeting Washington State residency requirements.	HCS provider has documentation of Washington State residency.
For clients who are HIV positive and out of care, eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive and out of care.	HCS provider has documentation of HIV status.

EIS Plan

Purpose: Provider develops an individualized service plan that supports need for Early Intervention Services.

Standard	Criteria	Documentation
HCS provider must assess needs and status of each client receiving EIS to assure compliance with service requirements.	HCS Provider assesses client needs and status.	HCS provider tracks assessments.
HCS providers develop an individualized service plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each actions	HCS provider documentation that each client has an individualized service plan that contains required elements.

HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

Service Coordination

Purpose: Providers focus on expanding key points of entry into HCS.

Standard	Criteria	Documentation
Providers provide EIS at or in coordination with documented key points of entry.	HCS provider establishes Memoranda of Understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive.	HCS provider has signed and dated MOU that outlines the responsibilities, obligations of each party.
HCS supplements and does not supplant existing funds for testing.	HCS providers use EIS funds for HIV testing only where existing federal, state, and local funds are not available.	HCS provider has policy and procedures on file.
EIS include referral to appropriate services based on HIV status.	HCS providers refer individuals to appropriate health care and supportive services based on HIV status.	HSC provider documents the number of referrals for health care and supportive services based on individuals HIV status.
EIS include linkage to appropriate services based on HIV status.	HCS providers link individuals to appropriate health care and supportive services based on HIV status.	HSC provider documents the number of linkages to health care and supportive services based on individuals HIV status.
EIS include health education and literacy training to navigate the HIV system of care.	HCS providers provide individuals health education and literacy training to help navigate the HIV system of care.	HSC provider documents the training and education sessions designed to help individuals navigate and understand the HIV system of care.

Staff Qualifications

Purpose: The provider will assure that HIV testing activities and methods meet CDC and state requirements.

Standard	Criteria	Documentation
Trained staff provides EIS services.	Trained EIS staff provides these services.	Personnel files, resumes or employment applications, reflect requisite experience or education.
Staff providing HIV testing activities will operate in accordance with local, State, and federal guidelines.	Provider has a system in place that documents that HIV testing activities and methods meet CDC and state requirements.	HSC provider documents that HIV testing activities and methods meet CDC and state requirements.
HCS provider must structure outreach activities targeting specific at risk populations.	HCS Provider has a policy in place that clearly states provider will target populations at high risk.	HSC provider has policies and procedures addressing how subrecipient will reach the target population.

Records Management

Purpose: Documentation is evidence of the provision of all four required service components: counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system.

Standard	Criteria	Documentation
HCS provider must provide or assure seamless linkage of these services: (1) counseling and HIV testing, (2) referral to appropriate services based on HIV status, (3) linkage to care, and (4) education and health literacy training for clients to help them navigate the HIV care system.	HCS provider has a system to document the provision of, or assurance of seamless linkage, of the four service components.	Provider documents provision of, or seamless linkage of, all four required EIS service components.
HCS provider will report on numbers of HIV tests and positives, as well as where HIV testing occurs.	Provider has a system to document number of HIV tests and positives, as well as where HIV testing occurs.	Provider reports the number of HIV tests conducted and number of positives found.
		Provider reports where HIV testing occurs and number of tests provided.
HCS provider tracks referrals for health care and supportive services.	HCS provider tracks referrals for health care and supportive services.	Provider reports referrals for health care and supportive services based on HIV status.
	HCS provider monitors referrals into care and treatment.	Provider reports referrals from key points of entry to EIS programs.
HCS provides training and education sessions designed to help individuals understand and navigate the HIV system of care.	Provider has a system to document training and education sessions that help individuals navigate and understand the HIV care system.	Provider documents numbers of training and education sessions that help individuals navigate and understand the HIV care system.
		Provider reports number of training and education sessions designed to help HIV negative individuals navigate and understand the HIV system of care.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness.	Provider reports on Performance Indicators and Outcome Measures.

Food Bank/Home-Delivered Meals

Service Category Definition

Food Bank/Home-delivered meals are the provision of actual food items, hot meals, or food vouchers to purchase food. Nutritional supplements can be included in food bank expenditures.

This also includes the provision of essential non-food items that are limited to the following:
- Personal hygiene products
- Household cleaning supplies
- Water filtration or purification systems in communities where issues of water safety exist

Client Characteristics

This services if for PLWH whose lack of access to food prevents them from obtaining medical care, staying in medical care, remaining adherent to treatment, or achieving expected health outcomes.

Unit of Service

A service unit of Food Bank/Home-delivered meals is an instance of a client receiving food, a voucher for food, or other resources allowable under this service category.

Strategies
- Provider will distribute food bags, vouchers, and essential non-food items to PLWH
- Provider will consider poverty, capacity, stigma, and health disparity related barriers to food security and attempt resolution through provision of food assistance or other available resources.
- Provider must document ongoing food insecurity needs in the Client's Service Plan.
- Provider must explore and strategize long-term sustainable resolutions
- Provider must use food or meal disbursement as payer of last resort.

Key Services Components and Activities
- Eligibility determination
- Food bank/home-delivered meals plan
- Food safety
- Volunteers
- Records management

Data

Providers must document and be prepared to share with DOH the design, implementation, target areas, populations, and outcomes of food bank/home-delivered meal services, including:
- Number of individual clients provided food bank/home-delivered meal services
- Food bank/home-delivered meal services provided by type of service

Standards

Eligibility Criteria

Purpose: Providers of food bank/home-delivered meal services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation are in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Food Bank/Home-delivered meals are provided to HIV positive persons who need help with food services to reduce food insecurity, hunger, and improve health outcomes.	HCS provider assesses client need for Food Bank/Home-delivered meal services.	HCS provider has documentation that client needs help with food services to reduce food insecurity, hunger, and improve health outcomes.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For Food Bank/Home delivered Meal Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For Food Bank/Home delivered Meal Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific to funding source.	HCS provider has documentation of Washington State residency specific to funding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.
Food Bank/Home-delivered Meal services are limited to the following types of needs: FOOD - Actual food items - Nutritional supplements - Prepared meals - A voucher program to purchase food NON-FOOD Items - Personal hygiene products - Household cleaning supplies - Water filtration/purification systems in communities where issues of water safety exist	HCS provider will follow limitations on usage as outlined in the standards.	HCS provider has documentation that funding was limited to the allowable usage categories.

HCS provider must assess needs and status of each client receiving Food Bank/Home-delivered meals at least once a year to assure compliance with care plan and service requirements.	HCS Provider assesses client needs and status at least once a year.	HCS provider tracks assessments in the client's individual service plan.

Food Bank/Home-delivered Meals Plan

Purpose: The provider evaluates the client's nutritional needs and preferred method(s) of access. The Food Bank/Home-delivered Meals Plan may be a sub-component of the client's Case Management ISP.

Standard	Criteria	Documentation
HCS provider will work collaboratively with the client to assess client's nutritional needs.	HCS provider assesses client's food needs at the client's intake, service plan reassessment, or request.	Provider has documentation of an assessment that demonstrates client needs food support.
HCS providers develop an individualized service plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each action	HCS provider documentation that each client has an individualized service plan that contains required elements.
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.
HCS provider will work collaboratively with the client to maximize Client's access to this service.	HCS provider's assessment includes the client's preferred way to access this service.	Provider has a written schedule for food distribution for on-site and home-delivered meals.

Food Safety

Purpose: The provider will adhere to all federal, state, and local public health food safety regulations to ensure the health and safety of clients.

Standard	Criteria	Documentation
HCS provider will obtain appropriate licensure/certification for Food Bank/Home-delivered meals, where required under State or local regulation.	HCS provider maintains any required licensure/certifications at all times while providing services.	HCS provider has documentation of any required licensure/certification.
	HCS provider has a procedure to ensure all required licensure/certifications are up to date.	

HCS provider shall adhere to all federal, state, and local public health food safety regulations.	HCS Provider meets all requirements of the local health jurisdiction for food handling and storage.	HCS provider will maintain file records of local health department food handling/food safety inspections.

Volunteers

Purpose: Providers may use volunteers to expand program capacity to provide Food Bank/Home-delivered meals.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	Provider will orient volunteers who have client contact prior to providing services.	Provider has a volunteer orientation curriculum.
	Qualified program staff will supervise all volunteers.	Evidence of : - Volunteer application - Training - Supervision
		Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

Records Management

Purpose: Service providers link clients with access to nutritional needs. Documentation is evidence that client received Food Bank/Home-delivered Meal services. Vouchers must be securely stored and securely transferred with limited staff access.

Standard	Criteria	Documentation
Food Bank/Home-delivered meals records are complete accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Food Bank/Home-delivered meals Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher or tracking of voucher's unique bar code
	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document services in case notes with corresponding service units and dollar amount.
HCS provider will ensure security of vouchers.	HCS provider has policy ensuring security of vouchers.	HCS provider has policy and procedures on file.
	Staff is aware of policy and procedures.	
HCS provider tracks distribution of vouchers.	Provider has system in place to track distribution of vouchers.	HCS provider has policy and procedures on file.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness.	Provider reports on Performance Indicators and Outcome Measures.

Health Education/Risk Reduction

Service Delivery Definition

Health Education/Risk Reduction (HE/RR) is the provision of education to clients living with HIV about HIV transmission and risk reduction. It includes sharing information about medical and social support services and counseling with clients to improve their health status. Providers cannot deliver HE/RR services anonymously.

Topics covered may include:

·   Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
·   Education on health care coverage options (e.g. qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
·   Health literacy
·   Treatment adherence education

Client Characteristics

Eligible clients are PLWH who exhibit high-risk behaviors and need interpersonal skills to change their behavior and lower their risk of transmitting HIV disease.

Unit of Service

· Individual educational activities
· Educational outreach activities in venues for at risk populations
· Educational group activities
· Referrals of consenting clients to primary medical care

Strategies

Provider will provide education to clients living with HIV about HIV transmission and risk reduction in a programmatic way. Provider will provide quantified reporting of activities and outcomes to accommodate evaluation of effectiveness.

Key Services Components and Activities

- Eligibility
- Health education and risk reduction plan
- Health educator qualifications
- Record management

Data

Providers must document and be prepared to share with DOH, the design, implementation, target areas, populations, and outcomes of HE/RR activities, including:

-   Number of individual clients provided HE/RR services
-   Number of group HE/RR services and activities provided
-   Number of PLWH reached

Standards

Eligibility Criteria

Purpose: Providers of linguistic services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Health education/risk-reduction services are for HIV positive persons who exhibit high-risk behaviors and need interpersonal skills to change their behavior and lower their risk of transmitting HIV disease.	HCS provider assesses client need for health education or risk-reduction services.	HCS provider has documentation that client needs health education/risk reduction services to remain in medical care or stay adherent to medications.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For HE/RR Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For HE/RR Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific to funding source.	HCS provider has documentation of Washington State residency specific of founding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.

Health Education and Risk Reduction Plan

Purpose: Development of a Health Education and Risk Reduction individualized plan that supports and sustains health behaviors to reduce, limit, and ultimately eliminate HIV related health risks. The HE/RR Plan may be a sub-component of the client's Case Management ISP.

Standard	Criteria	Documentation
HCS providers develop a HE/RR individualized plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action	HCS provider documentation that each HE/RR client has an individualized service plan that contains required elements.

	- Target date for completion of each action - Results of each actions	
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

Health Educator Qualifications

Purpose: Providers of HE/RR activities must complete minimum training requirements. Community health workers or peer workers involved in recruitment and engagement, screening, and coordination of services possess basic knowledge and communication skills.

Standard	Criteria	Documentation
HE/RR educators must complete minimum training requirements in the following areas: - HIV prevention and clinical issues - Sexually transmitted diseases prevention and clinical issues - Fundamentals of HIV testing	HCS HE/RR educators have completed minimum training requirements will provide complete minimum training requirements.	HCS provider has documentation that HE/RR educators have completed the minimum training requirements. HE/RR educators' personnel files are available for review.
Community health workers or peer workers used to recruit and engage clients have: · Knowledge of target populations · Cultural and linguistic competency · Knowledge of HIV and sexually transmitted diseases · Knowledge of community services · Effective communication skills	HCS HE/RR educators possess basic knowledge and communication skills.	HCS provider has documentation that subrecipient trains HCS HE/RR educators in HIV, sexually transmitted diseases, community services, and communication skills.

Records Management

Purpose: Documentation provides proof that client received HE/RR services.

Standard	Criteria	Documentation
HE/RR records will reflect compliance with the HE/RR outlined above. Records must be	HCS provider will maintain records for each client served.	HE/RR records include: - Date client received assistance - Documentation that client meets eligibility criteria

complete, accurate, confidential, and secure.	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document HE/RR services in case notes with corresponding service units.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness.	Provider is able to report on Performance Indicators and Outcome Measures.

Housing Services

Service Category Definition

Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing and related subsidies to enable a client or family to gain or maintain outpatient/ambulatory health services. The goal of Housing Services is to support PLWH with safe and secure temporary housing that will enable a client to enroll in or maintain participation in medical care while the case manager and client develop a long-term housing placement plan.

Housing services must not duplicate, and must be coordinated with, the assistance provided by the Housing Opportunities for Persons with AIDS (HOPWA) program. Assistance must support housing options that are feasible for the client to sustain beyond support provided through HCS funding.

Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

·   Provider must have mechanisms in place to allow newly identified clients access to housing services
·   Upon request, provider must provide DOH with an individualized written housing plan, consistent with each client receiving short term, transitional, and emergency housing services.
·   DOH uses the HUD definition of transitional housing, which defines transitional housing as up to 24 months.
·   Housing services must not duplicate, and must be coordinated with, the assistance provided by the HOPWA.
·   Assistance must support housing options that are feasible for the client to sustain beyond support provided through HCS funding.
·   Housing services funds cannot be in the form of direct cash payments to clients and clients cannot use funds for mortgage payments.

Client Characteristics

This service is for PLWH who are on a wait-list for housing assistance or are in an unstable housing situation that is preventing them from obtaining medical care, staying in medical care, remaining adherent to treatment, or achieving expected health outcomes.

Unit of Service

· Bed nights of hotel/motel vouchers provided
· Bed nights of transitional housing days
· Bed nights in an emergency shelter
· Bed nights in permanent supportive housing
· Total cost of utility assistance provided
· Total cost of deposit assistance provided
· Total cost of application fee assistance provided

Strategies

- Provider will provide housing support to PLWH through housing vouchers and hotel stays.
- Provider will consider poverty, capacity, mental health, substance use and stigma related barriers to housing stability and provide directly, or through referral and linkage, services to support and address any of these connected life domains.
- Intentionally track and address Health Disparities for Populations of Interest within each community as related to Housing services and outcomes.
- Housing direct assists must be payer of last resort.

Key Services Components and Activities

- Eligibility determination
- Housing plan
- Completion of Housing Application
- Develop long-term housing placement plan
- Expenditure monitoring

Data

Providers must document and be prepared to share with the Department the design, implementation, target areas, populations, and outcomes of housing services, including:

- Number of individual clients provided housing or related services
- Bed nights of housing services provided by type of service
- Total cost of utility, deposit or application fee assistance provided

Standards

Eligibility Criteria

Purpose: Providers of housing assistance services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Providers provide housing services to HIV positive persons who need services to reduce housing insecurity and improve health outcomes.	HCS provider assesses client need for Housing services.	HCS provider has documentation that client needs help with housing services to reduce shelter insecurity, and improve health outcomes.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For Housing Services funded by DOH, eligibility for services will include residency in WA State	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.

outside the TGA (King, Snohomish, and Island Counties). For Housing Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).		
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.
Housing services are limited to the following types of needs: RENT - Rent - Past-due rent - Rental deposit - First month's rent - Rental application or background check fees - Lot rent UTILITIES - Essential utilities (gas, electric, water, propane) - Essential utility deposit - Past-due essential utilities HOTEL or MOTEL or SHELTER - Hotel or Motel or Shelter voucher OTHER - Services as approved by WA DOH	HCS provider will follow limitations on usage guidelines.	HCS provider has documentation that funding was limited to the allowable usage categories
Eligibility for housing services must include evidence of tenancy or residency.	Client must demonstrate that they are one of the following: 1. The named tenant on the lease or account 2. A resident in the dwelling 3. Have a responsibility to pay rent	Client file includes evidence of tenancy or residency.

Housing Plan

Purpose: Housing assistance is limited to 24 months. To help clients transition to long-term housing placement, providers must work with client to develop a long-term housing placement plan. Providers must monitor client progress in reaching goals and objectives established in the long-term housing placement plan.

Standard	Criteria	Documentation
Housing services must be limited to short-term support of the allowable usage categories.	HCS provider will limit housing assistance to 24 months.	HCS provider will track usage in CAREWare.
	HCS provider will track utilization of assistance to ensure usage is short-	Provider has a tracking system

	term support of housing assistance needs.	
HCS provider must assist the client in developing long-term housing placement plan	HCS Provider assists clients in developing a long-term housing placement plan that includes: - List of client service needs - Establishment of short and long-term objectives for housing assistance - Establishment of objectives to secure employment or public benefits for financial planning - Establishment of objectives for obtaining or staying in medical care - Establishment of objectives to address other issues identified in the assessment as barriers to stable housing - Objectives and action steps to meet short and long-term goals - Schedule of medical and supportive service appointments that client must keep to continue receiving housing services - Resources to be used to meet client goals - Documentation of clients participation in long-term housing placement planning process - Criteria for determination of goals	HCS provider has long-term housing placement plan in clients Service Plan.
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.
	HCS provider will complete an Assessment/reassessment at time of application or renewal.	
	For Rental Assistance, HCS provider must complete renewals every six months at minimum.	
	For Motel, Hotel, Shelter, Deposit, or Utilities Assistance, HCS provider must complete renewals every month at minimum.	

Application Completion

Purpose: All clients receiving housing assistance must have a completed application present in their file for each request.

Standard	Criteria	Documentation
HCS providers will complete Short Term Housing Assistance Application for each housing assistance request.	HCS provider has a procedure to complete application.	Application is complete and present in client file
HCS providers collect all required supporting documents.	HCS provider will collect all required documents based on the type of assistance requested.	Required supporting documents are present in client file with Short Term Housing Assistance Application.
	For rent, past-due rent, rental deposit, first months' rent, lot rent, or rental application, or background check fees: - Rental agreement or lease - Any additional forms your financial department requires (e.g. W-9)	
	For utilities, utility deposit, past-due utilities: - Utility bill - Any additional forms your financial department requires (e.g. W-9)	
	For hotel/motel vouchers: - Statement including costs - Any additional forms your financial department requires (e.g. W-9)	

Expenditure Monitoring

Purpose: Housing Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded providers must be able to track the total amount of housing assistance provided.

Standard	Criteria	Documentation
HCS providers will effectively use and allocate expenditures.	HCS provider has a procedure to monitor or manage expenditures of Housing Assistance that ensures funding will be available throughout the program year.	HCS provider has tracking system that verifies expenditures.
HCS providers cannot make payment directly to clients, family, or household members.	Provide mechanism through which providers can make payment on behalf of the client.	HCS provider produces and maintains documentation that ensures providers made payments to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Housing Assistance.

Standard	Criteria	Documentation

Housing Assistance records will reflect compliance with the Housing Assistance Standards outlined above. Records must be complete, accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Housing Assistance Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher
	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document Housing Assistance services in case notes with corresponding service units (equal to bed nights for all Rent, Motel, or Hotel subsidies) and dollar amount.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness	Provider is able to report on Performance Indicators and Outcome Measures

Linguistic Services

Service Category Definition

Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. Qualified linguistic service providers provide these services. Services are a component of HIV service delivery between the healthcare provider and the client. Agencies use linguistic services to facilitate communication between the provider and client or support delivery of eligible services.

Client Characteristics

PLWH who need linguistic services to facilitate communication with core medical and support services providers.

Unit of Service

· Individual linguistic assistance

Strategies

Provider will offer interpretation services for PLWH receiving HCS.

Key Services Components and Activities

- Eligibility
- Linguistics plan
- Trained staff provide linguistically appropriate services
- Coordinating use of volunteers
- Records management

Data

Providers must document and be prepared to share with DOH the design, implementation, target areas, populations, and outcomes of linguistic services, including:

- o Number of individual clients provided linguistic services
- o Languages involved
- o Types of services provided
  - Oral interpretation
  - Written translation
  - Group or individual

Standards

Eligibility

Purpose: Providers of linguistic services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Linguistic services are provided to HIV positive persons who need translation assistance to obtain core medical or support services	HCS provider assesses client need for Linguistic services.	HCS provider has documentation that client needs help with translation services to obtain core medical or support services
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For Linguistic Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For Linguistic Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.

Linguistics Plan

Purpose: HCS provider creates an individualized service plan that supports need for Linguistic Services. The Linguistics Plan may be a sub-component of the client's Case Management ISP.

Standard	Criteria	Documentation
HCS providers develop an individualized service plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each actions	HCS provider documentation that each client has an individualized service plan that contains required elements.
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the

		Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

Trained Staff Provide Linguistically Appropriate Services

Purpose: Trained and qualified individuals holding appropriate state or local certification provide linguistic services.

Standard	Criteria	Documentation
Providers of Linguistic services meet training and qualifications based on available State or local certification.	All linguistic service providers possess appropriate training and hold relevant State of local certification.	Documentation that shows interpreter or translator has appropriate training and hold relevant State or local certification.

Volunteers

Purpose: Providers may use volunteers to expand program capacity to provide Linguistic Services.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	Provider orients volunteers who have client contact prior to providing services.	Provider has orientation curriculum on file.
	Qualified program staff will supervise volunteers.	Evidence of : - Volunteer application - Training - Supervision
		Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

Records Management

Purpose: Documentation is written proof or evidence that client received Linguistic Services.

Standard	Criteria	Documentation
Linguistic Services records will reflect compliance with the Linguistic Assistance Standards outlined above. Records must be complete, accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Linguistic Services Records include: - Date client received assistance - Type of provider requesting and receiving service - Type of service provided - Documentation that client meets eligibility criteria
Records track utilization of assistance.	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document linguistic services in case notes with corresponding service units
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness	Provider reports on Performance Indicators and Outcome Measures

Medical Transportation

Service Category Definition

Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or stay in core medical and support services.

Agencies may provide medical transportation through:
- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but must not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher system

Unallowable costs include:
- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Client Characteristics

PLWH whose lack of access to transportation services is preventing them from obtaining medical care, staying in medical care, remaining adherent to treatment, or achieving expected health outcomes.

Unit of Service

A service unit medical transportation is an instance of a client receiving transportation services, mileage reimbursement, or a voucher.

Strategies
- Provider will issue fuel cards, taxi vouchers, and bus passes to PLWH to enable access to medical care and support services.
- Provider will consider poverty, capacity, stigma, and health disparity related barriers to transportation and attempt resolution through provision of medical transportation assistance or other available resources. Provider will verify linkage of PLWH to HIV care and treatment services.
- Ongoing medical transportation needs must be in the Client's Service Plan.
- Provider must explore and strategize long-term sustainable resolutions.
- Medical Transportation direct assists must be payer of last resort.

Key Services Components and Activities
- Eligibility determination
- Medical transportation plan
- Distribution of vouchers, tokens, or passes
- Volunteers

- Records management

Data

Providers must document and be prepared to share with the Department. The design, implementation, target areas, populations, and outcomes of medical transportation services, including:

- Number of individuals clients provided medical transportation services
- Medical transportation services provided by type of service and cost

Standards

Eligibility Criteria

Purpose: Providers of medical transportation services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Medical transportation services are for HIV positive persons who need help with medical transportation services to access or stay in core medical and support services.	HCS provider assesses client need for medical transportation services.	HCS provider has documentation that client needs medical transportation services to access or stay in core medical and support services.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency.

For Medical Transportation Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties).

For Medical Transportation Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties). | HCS provider will provide services to clients meeting Washington State residency requirements, specific of funding source. | HCS provider has documentation of Washington State residency, specific of funding source. |
| Eligibility for services will include client is HIV positive. | HCS provider will provide services to clients who are HIV positive. | HCS provider has documentation of HIV status. |

Medical transportation services include the following: - Contracts with providers of transportation services - Mileage reimbursement (through a non-cash system) not to exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject) - Organization and use of volunteer drivers - Voucher or token systems (bus passes, tokes, gas cards) - Taxi cabs services invoiced to provider at cost	HCS provider will follow limitations on usage guidelines.	HCS provider has documentation that funding was limited to the allowable usage categories

Medical Transportation Plan

Purpose: HCS provider develops an individualized service plan that supports need for Medical Transportation Services. The Medical Transportation Plan may be a sub-component of the client's Case Management ISP.

Standard	Criteria	Documentation
HCS provider must assess needs and status of each client receiving medical transportation services.	HCS Provider assesses client needs.	Using CAREWare, HIV Community Service provider will document medical transportation services in case notes with corresponding service units and dollar amount.
HCS providers develop an individualized service plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each actions	HCS provider documentation that each client has an individualized service plan that contains required elements.
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

Distribution of Vouchers or Passes

Purpose: The provider will assure procedures are in place regarding use and distribution of vouchers, tokens, bus passes, and ferry passes.

Standard	Criteria	Documentation
A system is in place to account for the purchase and distribution of vouchers, tokens, or passes.	HCS provider maintains a system for documenting the purchase and distribution of vouchers, tokens, or passes.	HCS provider has documentation of purchase and distribution of vouchers, tokens, or passes.
	A security system is in place for storage of, and access to, vouchers, tokens, and passes.	
	Provider limits the number of vouchers or passes to no more than a months' supply.	
HCS provider does not provide direct transportation services to clients in need of emergency medical care and there is a policy to address this.	HCS Provider has a policy in place that clearly states provider will not provide direct transportation services to clients in need of emergency medical care.	Provider has a policy against providing direct transportation services to clients in need of emergency medical care.

Volunteers

Purpose: Providers may use volunteers to expand program capacity to provide Medical Transportation Services.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	Providers will orient volunteers who have client contact prior to providing services.	Provider has an orientation curriculum on file.
	Qualified volunteers will supervise volunteers.	Evidence of : - Volunteer application - Training - Supervision
		Signed & dated form on file that outlines responsibilities, obligations, & liabilities volunteer.

Records Management

Purpose: Documentation is proof of evidence that client received Medical Transportation services. Vouchers must be securely stored and securely transferred with limited staff access. Providers will keep these vouchers in locked and secure storage. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards

Standard	Criteria	Documentation
Medical Transportation Service records will reflect compliance with standards outlined above. Records are complete accurate, confidential, secure.	HCS provider will maintain records for each client served.	Medical Transportation Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher
	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document services in case notes with corresponding service units and dollar amount.
HCS provider will develop policy to ensure security of vouchers.	HCS provider has policy ensuring security of vouchers.	HCS provider has policy and procedures on file.
	Staff is aware of policy & procedures.	
HCS provider tracks distribution of vouchers	Provider has system in place to track distribution of vouchers.	HCS provider has policy and procedures on file.
HCS provider verifies that the client used medical transportation services to access medical or supportive services.	Provider has system in place to verify that client used medical transportation services to access medical or supportive services.	HCS provider has policy and procedures on file.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results for evaluation of effectiveness	Provider is able to report on Performance Indicators and Outcome Measures

Mental Health Services

Service Category Definition

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to consumers living with HIV. The goal of Mental Health Services is to provide PLWH with the highest quality service through trained, experienced, and appropriately licensed and credentialed providers.

Mental health providers must base services on a treatment plan and conduct services in an outpatient group or individual session. A mental health professional licensed or authorized within Washington State must render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Client Characteristics

This service is for PLWH whose mental health prevents them from obtaining medical care, staying in medical care, remaining adherent to treatment, or achieving expected health outcomes.

Unit of Service

Providers must document each Mental Health service unit. For example, one service unit equals:
- A mental health individual counseling session
- A mental health group counseling session

Strategies

- Using fee-for-service payment model, provider will provide outpatient mental or behavioral health or psychiatric support services for clients who are not able to access services by another payer source (EIP, Medicaid, Medicare, insurance).
- Apply cultural humility in the creation, implementation, and delivery of all services related to mental health/behavioral health treatment to minimize stigma and optimize consumer participation and success.
- Intentionally track and address Health Disparities for Populations of Interest within each community as related to Substance Abuse services and outcomes.
- Meaningfully incorporate consumer feedback into program design, implementation, and evaluation.
- Mental health direct assists must be used as payer of last resort

Key Services Components and Activities

- Eligibility determination
- Mental health plan
- Access to treatment
- Ensuring payer of last resort
- Providing access to treatment
- Coordination and referral
- Expenditure monitoring
- Records management

Data

Providers must document and be prepared to share with DOH the design, implementation, target areas, populations, and outcomes of mental health services, including:

- Number of individual receiving clients Mental Health services
- Mental Health services provided by type of service

Standards

Eligibility Criteria

Purpose: Providers of mental health services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Mental Health services are limited to psychological and psychiatric treatment and counseling services for PLWH with a diagnosed mental illness.	HCS provider will follow limitations on usage guidelines.	HCS provider has documentation that funding was limited to the allowable usage categories
Mental Health Services are for HIV positive persons who need help coping with emotional and psychosocial issues that affect health outcomes.	HCS provider assesses client need for Mental Health services.	HCS provider has documentation that client needs help with mental health issues to improve health outcomes.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For Mental Health services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For Mental Health Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.

Mental Health Plan

Purpose: HCS provider develops an individualized service plan that supports need for Mental Health. The Mental Health Plan may be a sub-component of the client's Case Management ISP.

PLWH Standards – Mental Health Services

Standard	Criteria	Documentation
HCS provider must assess needs and status of each client receiving Mental Health Services	HCS Provider assesses client mental health needs	HCS provider will track assessments in CAREWare.
HCS providers develop an individualized service plan with each client served.	HCS Provider assists clients in developing a long-term plan that includes: - Goal - Expected outcomes - Actions taken to achieve goal - Persons responsible for offering such action - Target date for completion of each action - Results of each actions	HCS provider documentation that each client has an individualized service plan that contains required elements.
HCS provider reassesses client need for service on a regular basis.	HCS provider will track assessment of client need.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

Access to Treatment

Purpose: The provider will provide clients with the highest quality service through trained, experienced, and appropriately licensed and credentialed staff members.

Standard	Criteria	Documentation
Clients will receive Mental Health Services from appropriately licensed and credentialed providers.	Mental health provider has a current license/certification for providing Mental Health Services in Washington.	HCS provider has a copy of Washington License or Certificate for every mental health provider receiving payment.
	HCS provider has a procedure to ensure all required licensure/certifications are up to date.	
PLWH will be able to access services in a timely manner.	Mental health providers will have policies and procedures that facilitate timely, medically appropriate care.	HCS provider's Mental Health Services policies and procedures indicate how needs of clients are managed.

Coordination and Referral

Purpose: HCS providers that do not directly provide Mental Health Services must actively facilitate the process and ensure clients have access to appropriate care. The referral process must include timely follow-up of all referrals to ensure that clients receive services. Subrecipient must consider mental health providers' eligibility requirements as part of the referral process.

Standard	Criteria	Documentation

HCS providers who do not directly provide Mental Health Services must systematically provide access to services.	HCS provider will initiate referrals for which the client and the provider agree. Referrals/referral process should include: - The name of a contact person at the referred provider - An exact address - Assisting clients with making and keeping appointments - Identifying referral provider eligibility requirements - Assisting clients to gather required documents to bring to the appointment	Provider documents the elements of linked referrals in Case Notes and in Care Plan.
HCS providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the mental health provider.	Providers obtain signed release of information forms as necessary.	Signed release of information is in client file.
HCS providers will identify and assist in resolving any barriers client may have that impede access to Mental Health Services.	HCS provider will work with client to identify barriers to referrals and facilitate access to referrals.	HCS provider will document all barriers identified in referral process and actions taken to resolve them in Case Notes and in Service Plan.
HCS provider will ensure clients are accessing referrals and services, and are following through with their referral plan.	HCS provider will utilize the Service Planer a tracking mechanism to monitor completion of all linked referrals.	HCS provider will document follow-up activities and outcomes in Case Notes, Service Plan, or through other tracking mechanisms. HCS provider will document client refusal of follow through or referral in CAREWare Case Notes.
	HCS providers promptly follow up with clients to ensure removable of barriers to accessing needed services.	
	HCS provider will document when a client refuses to follow through on a referral.	

Expenditure Management

Purpose: Mental Health Services assistance requires monitoring of expenditures to ensure funding will be available throughout the program year. Funded providers must be able to track the total amount of Mental Health Services funding provided.

Standard	Criteria	Documentation
HCS provider will effectively utilize and allocate expenditures.	HCS provider has a procedure to monitor and manage expenditures for Mental Health Services that ensures funding will be available throughout the program year.	HCS provider has a tracking system in place it updates monthly or when services are provided/paid.

	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document services in case notes with corresponding service units.
HCS provider verifies that client cannot access Mental Health Services through other payers, such as Early Intervention Program, Medicaid, Health Insurance	Provider has system in place to verify that HCS funds are the payer of last resort.	HCS provider has policy and procedures on file that stipulate HCS funds are payer of last resort.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness	Provider is able to report on Performance Indicators and Outcome Measures

Records Management

Purpose: Documentation is evidence that client received Mental Health Services. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Criteria	Documentation
Mental Health Services records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Mental Health Services Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher
	HCS provider will track utilization of assistance.	Using CAREWare, HIV Community Service provider will document service units in Service Plan.

Outreach

Service Category

Outreach activities have as their principal purpose targeting and identifying individuals with HIV disease who know their HIV status and are not in care, have not returned for treatment services, or do not adhere with treatment requirements. Outreach activities assist these individuals to become aware of the availability of HIV-related services and enroll in primary care, AIDS Drug Assistance Program, and support services that enable them to remain in care. Broad activities such as providing leaflets or posters do not qualify for outreach services. Outreach will ultimately reduce the number of people living with HIV who are not accessing the service delivery system.

Providers cannot deliver outreach services anonymously as DOH requires personally identifiable information for program reporting. HIV counseling or testing are not a component of outreach.

Program Guidance

Outreach programs must be:

- Conducted at times and in and places where there is a high probability that HIV-infected individuals will be reached.
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort and to address specific service need category identified through a needs assessment process
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at risk for HIV infection

Provider must design outreach services to:

· Establish and maintain an association with entities that have effective contact with persons disproportionately impacted by HIV or disproportionately differ in local access to care, e.g. prisons, homeless shelters, substance abuse treatment centers, etc.
· Direct individuals to early intervention services (EIS) or primary care (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services)
· Include appropriately trained and experienced workers to deliver the access to care message when applicable
· Provide quantifiable outcome measures (tracking and data collection) such as the number of individuals reached or previously unknown HIV status who know they are positive, or the number of HIV positive individuals not in care who are now in care

Goal of Service

The goal of Outpatient services is to link individuals into care that would ultimately result in ongoing primary care and increased adherence to medication regimens. Broad activities such as providing leaflets or posters do not quality for outreach services. Subrecipients have the flexibility to target and identify individuals who may or may not know their HIV status and are not in care, have not returned for treatment services, or do not adhered with treatment requirements. Outreach will ultimately reduce the number of people living with HIV who are not accessing the service delivery system.

Client Characteristics

PLWH who do not use available HIV services, have fallen out of care, are at risk for falling out of care, or know their status but are not in care.

Unit of Service

Providers must document each Outreach service unit. For example, one service unit equals:

- Outreach event held to identify those out of care or those that do not know their status.
- Referral provided to link client to medical care

Strategies

- Provide outreach services to identify clients who are not accessing HIV Community Services.
- Prioritize clients with known non-suppressed viral status as well as those with unknown viral status.
- Identify and collaborate with strategic partners, such as DOH Disease Intervention Specialist, local clinics, and providers, emergency rooms, social service organizations with overlapping scopes of work, missions, or clientele.
- Intentionally track and address health disparities for populations of interest within each community as related to outreach services and outcomes.
- Conduct outreach at times and in places where there is a high probability that HCS provider will reach HIV-infected individuals.

Key Activities

- Eligibility
- Client identification
- Providing information or education
- Engagement and retention activities
- Records management

Data

Providers must document and be prepared to share with DOH the design, implementation, target areas, populations, and type of Outreach services, including:

- Number of individual clients receiving Outreach services
- Outreach services provided by type of services

Standards

Eligibility

Providers of outreach services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.

Initial Determination of Eligibility for Case Management does not include Income.	HCS provider will provide services to eligible clients regardless of their FPL.	HCS provider collects and documents within CAREware Annual Review Tab information on Client FPL within thirty (30) days of initiating intake.
Eligibility for services will include Washington State residency. For Outreach Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For Outreach Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.

Client Identification

Purpose: This service must identify PLWH who do not use available HIV services, have fallen out of care, are at risk for falling out of care, or know their status but are not in care.

Standard	Criteria	Documentation
Working collaboratively with state and local outreach programs, the provider will identify clients who are aware of their HIV positive status, but not in care.	HCS outreach strives to identify those who could benefit from additional HIV care and treatment services.	Outreach plans and strategies demonstrate a systematic, evidence-based approach to client identification.
Provider conducts outreach efforts at times and places where there is a high probability of reaching PLWH.	Outreach providers must conduct formative research regarding the best location and time for reaching the target populations.	HCS provider documents research findings.
Provider plans and delivers outreach programs in coordination with state and local HIV-prevention outreach programs.	Outreach efforts must support, but not duplicate, existing efforts by HIV prevention providers.	HCS provider has inventory of other outreach providers and Memorandum of Understanding with medical and support service providers.

Providing Information or Education

Purpose: Outreach service providers will give potential clients clear, factual information suited to their needs.

Standard	Criteria	Documentation

Outreach must include information and education about HIV and the HIV service delivery system.	Outreach protocols and materials address: - The importance of accessing HIV care early in disease progression - Availability of HIV medical care, including means of financing such care - The availability of other core and support services - Preventing the further spread of HIV through sexual and injection behavior	Written materials and outreach protocols demonstrate the required components.
Outreach must include information and education about remaining in HIV care and accessing intensive services as needed.	Outreach protocols and materials address: - The importance of adherence to HIV medication and remaining in HIV care - The availability of other core and support services - Preventing the further spread of HIV through sexual and injection - Barriers and issues that challenge ongoing self-management	Written materials and outreach protocols demonstrate the required components.

Engagement and Retention

Purpose: Outreach programs must develop engagement and retention policies and procedures to ensure that the subrecipient makes every reasonable effort to bring or retain at-risk clients in care. Engagement and retention activities focus on clients who have fallen out of care or are at risk of falling out of care, and those clients aware of their HIV status but not currently in care.

Standard	Criteria	Documentation
Outreach providers ensure that they make every effort to bring or retain at-risk clients in care.	HIV outreach programs will develop engagement and retention policies and procedures.	Engagement and retention policies and procedures are on file.
Providers of maintenance outreach will complete a transition and case closure summary.	Provider documents attempts to contact the client and notifications about case closure in the patient file, along with the reason for transition or case closure.	Transition or case closure summaries include: - Date of engagement or retention activities - Efforts made to engage or retain - Reasons for transition or case closure and criteria for re-entry into services
	If client fails to respond to a less intensive outreach method, provider must use a more intensive method before case closure.	

Records Management

Purpose: Documentation is evidence that client received Outreach Services. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Criteria	Documentation
Outreach Services records will reflect compliance with standards. Records are complete accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Outreach services records include: - Date client received assistance
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider documents services in case notes with corresponding service units, and in service plan when client successfully engages

Psychosocial Support

Service Category Definition

Psychosocial Support Services provide group or individual support and counseling services that focus on empowerment, self-advocacy, and medical self-management. These services assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian

Through one-on-one interactions and in small groups, Psychosocial Support services support clients' engagement in health care and provide opportunities for education, skill-building, and emotional support in a respectful environment. Providers may <u>not</u> use funds to pay for:

- Social or recreational activities
- Client's gym membership

Client Characteristics

PLWH who need additional support outside of case management to develop strategies for living health lives.

Unit of Service

Providers must document each Psychosocial Support service unit. For example, one service unit equals:

- Bereavement, child abuse, or nutrition counseling session
- A HIV support group

Strategies

Provider will provide group-counseling services to PLWH to address health concerns as well as factors related to improving quality of life for PLWH.

Key Activities

- Eligibility
- Support Groups
- Counseling
- Referral
- Records management

Data

Providers must document and be prepared to share with DOH the design, implementation, target areas, populations, and outcomes of psychosocial individual support or support groups, including:

- Number of individual clients attending HIV support groups
- Number of individual clients receiving one-on-one support services

Standards

Eligibility

Purpose: Providers of psychosocial support services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Psychosocial support is for persons living with HIV who need assistance to empower themselves to develop healthier lives.	HCS provider assesses client need for psychosocial support services.	HCS provider has documentation that client needs psychosocial support services.
Initial Determination of Eligibility for Case Management does not include Income.	HCS provider will provide services to eligible clients regardless of their FPL.	HCS provider collects and documents within CAREware Annual Review Tab information on Client FPL within thirty (30) days of initiating intake.
Eligibility for services will include Washington State residency. For Psychosocial Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties). For Psychosocial Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.

Psychosocial support groups

Purpose: Psychosocial Support service providers may provide groups for people living with HIV. Topics are applicable to the target population with a focus on empowerment, self-advocacy, and medical self-management.

Standard	Criteria	Documentation
Psychosocial Support providers will offer client-driven, medically accurate group(s) to help improve the quality of life for participants.	Psychosocial group participants will receive support concerning: - Access to health and other benefits - Developing coping skills - Reducing feelings of social isolation - Increasing self-determination and self-advocacy	Psychosocial support providers will maintain group records that include: - Dated sign-in sheets - Number of participants attended - Name and title of group facilitator - Location of group - Copies of handouts - Summary of the topics discussed

		- Activities conducted - Goals and objectives achieved during group session

Counseling

Purpose: Psychosocial support service providers may provide bereavement counseling, child abuse or neglect counseling, or nutrition counseling to assist clients in being able to address behavioral and physical health concerns

Standard	Criteria	Documentation
Psychosocial Support providers will offer client-driven, medically accurate counseling to help improve the quality of life for participants.	Psychosocial individual counseling participants will receive support concerning: - Access to health and other benefits - Developing coping skills - Reducing feelings of social isolation - Increasing self-determination and self-advocacy - Nutrition	Psychosocial support providers will maintain client records that include: - Date - General topics discussed - Activities conducted - Goals and objectives achieved during counseling sessions

Referral

Purpose: Psychosocial support does not address highly complex behavioral health or case management issues. For these situations, providers must make referrals to a more appropriate service. Referrals must be appropriate to client situation, lifestyle, and need.

Standard	Criteria	Documentation
The provider will develop referral resources for services to meet the needs of their clients.	Provider will develop and maintain comprehensive referral lists for full range of services.	Referral lists will be available for inspection.
Providers will demonstrate active collaboration to provide referrals to the full spectrum of services.	Provider will collaborate with other providers to provide effective, appropriate referrals.	Subrecipient has a Memoranda of Understanding with service providers.
Client will receive referrals to those services critical to achieving optimal health and well-being.	The provider will support the client to initiate appropriate referrals.	The provider documents all referrals within Case Notes, Services, or Service Plans.

Records Management

Purpose: Documentation is evidence that client received Psychosocial Services. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Criteria	Documentation
Psychosocial support services records will reflect compliance with standards outlined above. Records are complete accurate, confidential, secure.	HCS provider will maintain records for each client served.	Psychosocial support services records include: - Date client received assistance
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider will document services in case notes with corresponding service units, and in service plan.

Substance Abuse Outpatient Services

Service Category Definition

Substance abuse outpatient services are the provision of the highest quality outpatient services by appropriately licensed and credentialed providers for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis
- Treatment of substance use disorder, including:
    - Pretreatment or recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Substance abuse providers base services on a treatment plan, conducted in an outpatient group or individual session, and provided by a substance abuse outpatient professional licensed or authorized within Washington State to render such services. Services provided must include a treatment plan that calls only for allowable activities and includes:

- The quantity, frequency, and modality of treatment provided
- The date treatment begins and ends
- Regular monitoring and assessment of client progress
- Signature of the individual providing the service

Client Characteristics

PLWH diagnosed with substance abuse issues and who need referral and treatment, including follow-up appointments or referral to ongoing support.

Unit of Service

Providers must document each substance abuse outpatient unit. For example, one service unit equals:
For example, one service unit equals:

· A substance abuse outpatient treatment session

· Substance abuse outpatient group counseling session

· Substance abuse Assessment

Strategies

- Using fee-for-service payment model, provider will provide outpatient substance abuse treatment services for clients who are not able to access services by another payer source (EIP, Medicaid, Medicare, insurance).
- Apply cultural humility in the creation, implementation, and delivery of all services related to substance abuse treatment.
- Intentionally track and address Health Disparities for Populations of Interest within each community as related to Substance Abuse services and outcomes.
- Meaningfully incorporate consumer feedback into program design, implementation, and evaluation.
- Outpatient substance abuse treatment direct assists must be used as payer of last resort

Key Activities

- Eligibility determination
- Access to treatment
- Treatment plan
- Coordination and referral
- Expenditure monitoring
- Records management

Data

Providers must document and be prepared to share with the Department the design, implementation, target areas, populations, and outcomes of substance abuse outpatient services, including:

- o Number of individual clients attending substance abuse outpatient services
- o Substance abuse outpatient services provided by type of services

Standards

Eligibility determination

Purpose: Providers of substance abuse outpatient services will determine, follow, and disseminate eligibility criteria. Further discussion of eligibility criteria, determination, and documentation is in Universal Standards – Eligibility.

Standard	Criteria	Documentation
Substance abuse outpatient services are for PLWH who need help coping with drug and alcohol issues that affect health outcomes.	HCS provider assesses client need for substance abuse outpatient services.	HCS provider has documentation that client needs help with drug or alcohol issues to improve health outcomes.
Eligibility for services will include FPL used by Early Intervention Program	HCS provider will provide services to eligible clients under the FPL guideline.	HCS provider has documentation of client FPL.
Eligibility for services will include Washington State residency. For Substance Abuse Services funded by DOH, eligibility for services will include residency in	HCS provider will provide services to clients meeting Washington State residency requirements specific of funding source.	HCS provider has documentation of Washington State residency specific of funding source.

WA State outside the TGA (King, Snohomish, and Island Counties). For Substance Abuse Services funded by PHSKC Ryan White, eligibility for services will include residency in WA State within the TGA (King, Snohomish, and Island Counties).		
Eligibility for services will include client is HIV positive.	HCS provider will provide services to clients who are HIV positive.	HCS provider has documentation of HIV status.
Providers pay for substance abuse outpatient services provided in an outpatient setting.	HCS provider assures that services are in an outpatient setting.	HCS provider has documentation that services occurred in an outpatient setting.

Substance Abuse Outpatient Treatment Service Plan

Purpose: Providers of substance abuse outpatient services must include a treatment plan that calls for only allowable activities.

Standard	Criteria	Documentation
Substance abuse outpatient services treatment plan includes only allowable activities and includes: (1) the quantity, frequency, and modality of treatment provided, (2) the date treatment begins and ends, (3) regular monitoring and assessment of client progress, (4) the signature of the individual providing the service.	Substance abuse outpatient services treatment plan includes the quantity, frequency, and modality of treatment provided.	Program files and client records include a treatment plan that includes the quantity, frequency, and modality of treatment provided.
	Substance abuse outpatient services treatment plan includes the date treatment begins and ends.	Client record includes a treatment plan that includes the date treatment begins and ends.
	Substance abuse outpatient services treatment plan includes regular monitoring and assessment of client progress.	Program files and client records include a treatment plan that includes regular monitoring and assessment of client progress.
	Substance abuse outpatient services treatment plan includes the signature of the individual providing the service.	Program files and client records include a treatment plan that includes the signature of the individual providing the service.

Access to Treatment

Purpose: The provider will provide clients with the highest quality service through trained, experienced, and appropriately licensed and credentialed staff members

Standard	Criteria	Documentation
Clients will receive substance abuse outpatient Services from a physician or qualified/licensed personnel.	Substance abuse outpatient provider has a current license/certification for providing substance abuse outpatient Services in Washington.	HCS provider has a copy of Washington License or Certificate for every substance abuse outpatient provider receiving payment.

	HCS provider has a procedure to ensure all required licensure/certifications are up to date.	
PLWH will be able to access services in a timely manner.	Substance abuse outpatient providers will have policies and procedures that facilitate timely, appropriate care.	HCS provider's substance abuse outpatient Services policies and procedures indicate how needs of clients are managed.

Coordination and Referral

Purpose: HCS providers that do not directly provide substance abuse outpatient services must actively facilitate the process and ensure clients have access to appropriate care. The referral process must include timely follow-up of all referrals. Provider eligibility requirements are part of the referral process.

Standard	Criteria	Documentation
HCS providers who do not directly provide substance abuse outpatient services must systematically provide access to services.	HCS provider will initiate referrals for which the client and the provider agree. Referrals/referral process should include: - The name of a contact person at the referred provider - An exact address - Assisting clients with making and keeping appointments - Identifying referral provider eligibility requirements - Assisting clients to gather required documents to bring to the appointment	Provider documents linked referrals in case notes and in care plan.
HCS providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the substance abuse outpatient provider.	Provider obtains signed release of information forms.	Signed release of information is in client file.
HCS providers will identify and assist in resolving any barriers client may have that impede access to substance abuse outpatient Services.	HCS provider will work with client to identify barriers to referrals and facilitate access to referrals.	HCS provider will document all barriers identified in referral process and actions taken to resolve them in case notes and in treatment plan.
HCS provider will ensure clients are accessing referrals and services, and are following through with their treatment plan.	HCS provider will utilize the service plan or a tracking mechanism to monitor completion of all linked referrals.	HCS provider will document follow-up activities and outcomes in case notes, service plan, or through other tracking mechanisms.
	Provider promptly assesses whether client is able to access services.	
	HCS provider will document when a client refuses to follow through on a referral.	

Expenditure Management

Purpose: Substance abuse outpatient services assistance requires monitoring of expenditures to ensure funding will be available throughout the program year. Funded providers must be able to track the total amount of substance abuse outpatient services funding provided.

Standard	Criteria	Documentation
HCS provider will effectively utilize and allocate expenditures.	HCS provider has a procedure to monitor and manage expenditures for substance abuse outpatient Services that ensures funding will be available throughout the program year.	Provider has an expenditure tracking system.
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider will document services in case notes with corresponding service units.
HCS provider verifies that client cannot access substance abuse outpatient Services through other payers, such as: - Early Intervention Program - Medicaid - Health Insurance	Provider has system in place to verify that HCS funds are the payer of last resort.	HCS provider has policy and procedures on file that stipulate HCS funds are payer of last resort.
HCS providers must be able to provide quantified program reporting activities.	Providers are able to provide quantified program reporting of activities and results to accommodate evaluation of effectiveness.	Provider is able to report on Performance Indicators and Outcome Measures.

Records Management

Purpose: Documentation is evidence that client received substance abuse outpatient services. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Criteria	Documentation
Substance abuse outpatient services records will reflect compliance with standards. Records are complete accurate, confidential, and secure.	HCS provider will maintain records for each client served.	Substance abuse outpatient Services Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider will document services in case notes with corresponding service units, and in service plan.

Program Monitoring

National Monitoring Standards

HRSA developed National Monitoring Standards to help Ryan White HIV/AIDS Program recipients and subrecipients improve program efficiency and responsiveness. They form the backbone of Washington's HIV Community Service Standards. National Monitoring Standards define federal requirements and expectations for program and fiscal management, monitoring, and reporting. To review the complete National Monitoring Standards, visit http://hab.hrsa/manageyourgrant/granteebasics.html.

Program monitoring means assessing the quality and quantity of the services provided. For DOH, monitoring includes reviewing program reports, conducting monitoring visits, and reviewing client records or charts. DOH requires providers to report the number of clients served, the types of services offered, and any barriers or problems associated with delivering services.

Quality Assurance

Quality assurance focuses on subrecipient compliance with a set of standards taken directly from the written contract and compiled in a quality assurance checklist. DOH uses assessment tools or checklists during periodic reviews or monitoring visits. These assessment tools may ask for information on fiscal controls, independent audit requirements, standards of care, client confidentiality provisions, and staffing patterns. DOH mandates provider compliance with eligibility determination or screening. DOH encourages subrecipients to develop a quality assurance checklist to use as a self-assessment tool.

Site Visits

DOH uses site visits to monitor their contracts. A site visit might include staff interviews, observation of services, a facility tour, and a review of documentation relating to the following aspects of subrecipient operations:

- Fiscal management system
- Staff licenses
- Insurance policies
- Client enrollment
- Client confidentiality protections
- Adherence to program and fiscal policies
- Data collection procedures
- Review of client charts

In large programs with multiple staff positions, the site visit monitor may want to review time and attendance records and interview staff at all levels including administrators, front-line staff, and support staff. A facility tour may address physical access issues. A review of documentation can include a wide range of information as is needed to satisfy local, State, and Federal contracting regulations.

Peer Review

Peer colleagues in the subrecipient organization should engage in a structured review of the program. Providers can best use this method to assess individual staff performance in case management and other programs that depend heavily on the quality of staff outputs.

Client Chart Reviews

DOH reviews client charts to assess a provider's performance with respect to standards of care and record-keeping requirements. The chart review typically involves on-site data collection by a monitoring team, data analysis, and out-briefs.

Plans for Corrective Actions or Remedial Steps

When problems with a subrecipient become apparent, DOH will undertake some form of corrective action. DOH and the subrecipient will meet first to discuss specific problems. Indicators for corrective action include the following:

- Under- or over-spending
- Improper invoicing
- Failure to meet program goals and objectives
- Repeated staff turnover and vacancies
- Missing or incomplete client records
- Failure to make reports in a timely manner
- Failure to appropriately serve an eligible client
- A variety of budget or work plan failures

DOH uses a graduated corrective action approach. The first priority is to assure that technical assistance (TA) is available to subrecipients. DOH will prompt a request for TA by verbally informing the subrecipient of problems and then in writing. If informal efforts fail and formal mechanisms are necessary, DOH will continue to work with the subrecipient before terminating the contract.

DOH may terminate a contract for default if the subrecipient has failed to comply with the conditions of the contract. DOH may also terminate a contract if it has a reasonable basis to believe that the subrecipient has:

- Failed to meet or maintain any requirement for contracting with DOH
- Failed to ensure the health or safety of any client for whom services are being provided
- Failed to perform under, or breached, any term or condition of the contract
- Violated any applicable law or regulation

Technical Assistance

TA programs provide subrecipients with resources that aid in the development or compliance of their programs. DOH provides on-site TA to assist, train, or guide subrecipients through contract requirements.

Records Management

Purpose: The records relating to core medical and support services must document that such services were used to link clients with health care, psychosocial services, and other service needs.

Documentation is written proof or evidence that the client received HIV Community Service assistance.

Standard	Criteria	Documentation
HCS records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.	HCS provider will maintain records for each client served.	HIV Community Services Records include: - Date client received assistance - Documentation that client meets eligibility criteria - Copy of check or voucher, if appropriate
	HCS provider will track utilization of assistance.	Using CAREWare, HCS provider will document services in case notes with corresponding service units, and in service plan.

Quality Improvement

Quality Management

A quality management program focuses on the extent to which services provided meet guidelines set for the prevention and treatment of HIV. Quality management includes assurance and improvement.

Clinical Quality Management

Title XXVI of the Public Health Service Act (Ryan White HIV/AIDS Program) requires a clinical quality management program to:

- Assess the extent to which HIV health services provided to patients are consistent with current Public Health Service guidelines (http://aidsinfo.nih.gov/Guidelines) for the treatment of HIV and related opportunistic infections
- Develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV services
- Ensure demographic, clinical, and utilization data are used to evaluate and address characteristics of the local epidemic and quality of care
- Ensure appropriate leaders and stakeholders are included throughout the quality improvement process
- Ensure continuous processes to improve quality of care are in motion

DOH has adopted these guidelines. They are the backbone of the HIV Community Services standards for quality improvement.

Quality Management Program Components[4]

A quality management program is the coordination of activities aimed at **improving** client care, health outcomes, and experience (satisfaction). To be effective, a quality management program should include,

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[4] US Department of Health and Human Services. 2015. Clinical Quality Management Policy Clarification Notice #15-02. Assessed at: https://hab.hrsa.gov/sites/default/files/hab/Global/clinicalqualitymanagementpcn.pdf

specific aims based on health outcomes, support by identified leadership, accountability, dedicated resources, and the use of data and measurable outcomes.

HCS Provider Requirements

Providers are required to:
- Have a quality management plan, based on DOH provided template or otherwise approved by DOH;
- Implement at least one quality improvement project each year, DOH prefers a project each quarter
- Enter data into CAREWare necessary to produce DOH selected Performance Measures
- Measure patient/client experience or satisfaction annually
- Submit quarterly quality management report using DOH provided template within 30 days after the end of each quarter
- Participate in DOH convened quality management activities, such as training and statewide quality management committee

Quality Management Plan

Department of Health will provide a template that includes all of the requirements of the quality management plan. If HCS provider wishes to use an alternative format, they must receive approval from the Quality Improvement Coordinator. All quality management plans must include a description of the quality infrastructure, performance measures, and quality improvement. Technical assistance is available from DOH upon request.

Quality Improvement Projects Model for Improvement (Plan Do Study Act (PDSA))

Providers should aim quality improvement projects at improving client care. The PDSA is a simple yet powerful tool for accelerating improvement.
- Plan: Identify the problems, including their components, then plan strategies and tests that might result in improvement
- Do: Use the strategies designed to address problems
- Study: Collect and analyze data to see if strategies have resulted in improvements
- Act: If the strategies are effective, make them an ongoing activity. If the strategies are not effective, return to the Plan stage and use data to identify new ways to address problems

Data Entry/Performance Measures

See the CAREWare section of this manual for data entry requirements. The performance measures that DOH uses to determine progress and to identify areas for improvement are:
- Engagement in Care Measure: Gap in HIV case management visit
- Engagement in Care Measure: Annual Medical Visits
- Engagement in Care Measure: HIV viral load testing
- Health Outcome Measure: HIV viral load suppression
- Special Population Health Outcome Measures: HIV viral load suppression for
    o Latinx
    o Black
    o Unstably housed

Quality Improvement

Client Experience

One measure of client experience is involvement in the quality management program. This ensures that the provider addresses needs of clients in quality management activities including the selection of quality improvement projects. Client satisfaction or experience surveys are one method for identifying areas for improvement. Clients should be involved in the design and testing of surveys. Subrecipients can find comprehensive information for conducting client surveys at http://www.nationalqualitycenter.org/resources/patient-satisfaction-survey-for-hiv-ambulatory-care-pdf/. DOH does not expect HCS providers to implement a survey of that size. DOH will be convening a workgroup to address client surveys.

Quarterly Reports

Department of Health will provide a template that includes all the requirements of the quarterly report. The quarterly report is due the last working day of the month following each calendar quarter. For the calendar year 2017, the quarters, and due dates are:

CALENDAR QUARTER	DUE DATE
JANUARY 1 – MARCH 31	APRIL 28
APRIL 1 – JUNE 30	JULY 31
JULY 1 – SEPTEMBER 30	OCTOBER 31
OCTOBER 1 – DECEMBER 31	JANUARY 31

DOH Convened Quality Management Activities

DOH may require HCS providers to participate in training activities, and webinars to improve quality management efforts. The DOH has a statewide quality management plan and encourages HCS providers to provide input on the selection of measures and quality improvement projects. DOH may ask HCS providers to participate in additional quality management activities.

Standards

Quality Improvement

Purpose: Providers must implement activities intended to improve performance through ongoing quality monitoring, evaluation, and improvement processes.

Standard	Criteria	Documentation
HCS providers will assemble an provider Quality Committee	Assemble a provider Quality Committee that actively includes clients as well as front line employees, supervisory staff, management staff, and key external collaborators and stakeholders.	HCS provider documents Quality Committee meetings, including: - Date of meeting - Minutes from each meeting - Number of people on the committee - Meeting attendance - Committee recommendations

Quality Improvement

HCS provider will develop and periodically update a written provider Quality Plan that is consistent with the Washington State Quality Plan.	HCS provider will develop a written provider Quality Plan that includes: - At least one of the performance measures from the Statewide Quality Plan - At least one of the statewide focus areas: access, adherence, retention, and evidence-based care	HCS provider has a Quality Improvement Plan on file.
	Quality Improvement Plans are updated at lease annually	HCS provider documents all updates to the Quality Improvement Plan upon achievement of goals, and when other issues or goals are identifies, or at lease annually.
Providers will undertake short-term Plan Do Study Act (PDSA) activities specifically aimed at evaluating and improving HIV program services.	Providers will collect, report, and analyze data regarding PDSA.	Provider has evidence of PDSA.
Providers use client satisfaction surveys and other efforts to gauge adequacy of services in meeting client needs.	Each provider must conduct periodic client satisfaction surveys, at least annually.	Provider submits a copy of the findings of the survey and other efforts to DOH.

Data

CAREWare Data Collection System

CAREWare is a free, electronic health and social support services information system for Ryan White HIV/AIDS Program grant recipients and their providers. HRSA's HIV/AIDS Bureau developed and released CAREWare in 2000. HRSA contracts with Jeff Murray Programming Shop (jProg) to develop and maintain CAREWare.

Washington State has a centralized CAREWare database. DOH and Ryan White Part A funded providers across the state access CAREWare through a secure connection. CAREWare provides DOH and Part A the ability to do statewide reporting and data analysis. Part A also uses CAREWare to generate the annual Ryan White Service Report.

Washington CAREWare is a secure, centralized, software application designed to report client-level data from HCS programs funded through the Washington State Department of Health and Public Health Seattle & King County. DOH uses HIV funds to support core medical and support services. DOH funded providers must use Washington State's CAREWare to report client information. Looking forward, CAREWare is the data collection platform for the combined efforts of HIV Prevention and Client Services in serving clients along the continuum of HIV care.

Data Entry

HCS Providers are required to create a CAREWare file within 48 business hours from the time of client intake.

HCS Providers are required to enter:

- Data in all required tabs or fields within thirty(30) days of initial client enrollment and five (5) days from any changes to client information
- Services and Case Notes within five (5) business days of the date of service

Reporting

Purpose: Providers must use CAREWare to track activities, enter case notes, update client demographics, document service provision, and report performance measures.

Standard	Criteria	Documentation
Provider must track each client receiving HCS services within thirty (30) days of Client Intake.	Provider enters client demographic data into CAREWare within thirty (30) days of Client Intake.	Client demographic data is in CAREWare within thirty (30) days of Client Intake.
Provider must update client Demographics within five (5) days from identified changes in client demographics	Provider updates client Demographics within five (5) business days from identified changes in client demographics	Client Demographics data is updated in CAREWare within five (5) business days from identified changes in client demographics
Provider must document services provided within five (5) business days from delivery of service, or interaction with or on behalf of client.	Provider documents services provided within five (5) business days from delivery of service, or interaction with or on behalf of client.	Provider enters services provided into CAREWare Service Tab within five (5) business days from delivery of service, or interaction with or on behalf of client.

Provider must document client housing, insurance, and income status within thirty (30) days from intake or five (5) business days from change in status.	Provider documents client housing, insurance, and income status within thirty (30) days of intake or five (5) business days from change in status.	Provider enters client housing, insurance, and income status into CAREWare Annual Review Tab within thirty days (30) from intake or five (5) business days from change in status.
Provider must document case notes within five (5) business days from provision of core or support services, or interaction with, or on behalf, of client.	Provider documents client case notes within five (5) business days from provision of core or support services, or interaction with, or on behalf, of client.	Provider enters case Notes into CAREWare Case Note Tab within five (5) business days from provision of core or support services, or interaction with, or on behalf, of client.
Provider must document client laboratory results within five (5) business days from receiving results from client or physician.	Provider documents client laboratory results within five (5) business days from receiving results from client or physician.	Provider enters client laboratory results into CAREWare Encounter Tab within five (5) business days from receiving results from client or physician.
Provider must document client information in DOH Custom Tabs within five (5) business days of changes in client status or service delivery.	Provider documents client information in DOH Custom Tabs within five (5) business days of changes in client status or service delivery.	Provider enters client Information or services into CAREWare Custom Tab within five (5) business days of changes in client status or service delivery.

Required Tabs/Fields

HCS providers are required to complete the following tabs or fields:

Demographic Tab

First Name (No nicknames)
Middle Name (optional)
Last Name
Date of Birth
Gender
Sex at Birth
Physical Address (If homeless, not required- please document)
City
State
Zip Code
County
Phone Number (If none, not required)
HIV Status
HIV+ Date
AIDS Date (If applicable)
HIV Risk Factor (this data element is the client's initial risk factor for HIV infection)
Report all of the response categories that apply:

- *Males who have sex with male(s) (MSM)* must be checked if a male client indicates sexual contact with other men. This must be checked regardless of sexual orientation (e.g. if a male client identifies as heterosexual but reports having sex with men).
- *Injection drug user (IDU)* must be checked when the client reports the use of intravenous drugs.
- Check *Hemophilia/coagulation disorder* when the client has Hemophilia or another blood clotting disorder.
- Check *Heterosexual contact* must be checked when a client reports sexual contact with a person of the opposite sex who is HIV+ or is at an increased risk of HIV infection.
- Check *Perinatal Transmission* if infected while in the mother's womb during gestation. Provider must also select if the client is under the age of two, and the HIV status is still undetermined.
- Check *Receipt of transfusion of blood, blood components, or tissue* must be checked when the client was the recipient of a tainted blood or tissue product that resulted in their HIV diagnosis.
- Check *Risk factor not reported or not identified* if the client's risk factor is unknown. This category also refers to HIV-affected clients who do not have a risk factor.

Ethnicity
- Along with any subgroups that may apply

Race
- Along with any subgroups that may apply

DOH allows sharing of Common Notes across all providers that serve the client. Common notes must only include information that all providers need to know. Providers often use common notes to communicate information between the Ryan White Provider and the ADAP office. Common Notes are not required.

DOH does not share Provider Notes across providers. DOH does not require Provider Notes.

Demographics Tab
- Ryan White Eligibility Status
- Vital Status
- Deceased Date (if applicable)
- Enrollment Status
- Enrollment Date
- Case closed (if applicable)

Annual Review Tab
- Insurance
    o Primary Insurance
    o Other Insurance (if applicable)
- Federal Poverty Level
    o Household Income

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- o Household Size
- Housing/Living Arrangement

Encounters

Providers must complete the Labs tab, which is within the Encounter tab. Within the Labs tab, the Ryan White Provider must enter the information on clients' Viral Load Date and Value.

Services

Each provider must track and report services. Providers are required to enter all services in CAREWare, along with a corresponding Contract, Service Unit, and Price, where appropriate.

The "Service" tab contains a list of funded services. DOH requires providers to enter service for every discrete contact with or on behalf of a client. The provider must link the services to a specific Service Name or a specific Service Category.

The "Date" field in the Service tab indicates the date the provider delivered the services, not the date on which the provider entered the service into CAREWare.

The "Service Name" includes a drop-down menu identifying a list of DOH funded services by Service Category. The table in the following section lists the Service Names.

The "Contract" field in CAREWare for DOH funded services is reserved for Acuity Measurement. There are two Contract selections. These are "DOH Engagement" and "DOH Retention". DOH Engagement refers to clients assessed as either High or Medium Acuity. DOH Retention refers to clients assessed as either Low Acuity or Preventative Support. The provider must choose the Contract based on the acuity of the client served. The one exception to this distinction involves the Service "CM HIV Related Medical Provider Visit". CAREWare connects this service to the contract "HAB Measures" only. The contract will be auto-selected in this case.

The "Unit" field depicts the number of a specific Service delivered on a specific date for a specific client. The provider can use the Unit field capture multiple of the same Services if they provided those services on the same date. The default Unit is one (1).

The "Price" field in the Service tab captures the cost of a tangible benefit dispensed. In these cases, "Price" reflects the dollar amount of a single unit of that item. CAREWare will calculate the "Cost" by multiplying the total "Unit" number by the "Price".

The exception to this involves certain DOH Housing Services only. For "DOH Housing Rent", "DOH Housing Motel", "DOH Housing Shelter", the "Unit" refers to total bed nights "purchased" using the DOH funding being entered into CAREWare. The "Price" reflects the cost per bed night. For a payment of

$600.00 on April 1, 2017, provided to cover rent for a total of 30 days, the CAREWare Service Tab entry would look as follows:

> Date: 04/01/2017
> Service Name: DOH Housing Rent
> Contract: DOH Engagement
> Unit: 30
> Price: $20.00
> Cost: $600.00 (auto-calculated by CAREWare)

Case Notes

Along with the service, providers must enter a Case Note. The Case Note provides a narrative format for HCS providers to document details of the service provided. A Case Note must contain the date, the author, the author's title, and a brief narrative. Narratives should include, at minimum, relevant details on what transpired in the interaction with or on behalf of the client, person(s) involved in the interaction, outcomes, and next steps. Only authorized staff of the subrecipient who entered the note and the DOH Statewide Case Management Coordinator can view content of the Case Notes without additional permissions. Providers must enter Services and Case Notes within five (5) business days of the service date.

	Sub-Service Name	RSR Service Category	DOH Engagement	DOH Retention	HAB Measure
	CASE MANAGEMENT				
	CM HIV Related Medical Visit	Outpatient/Ambulatory Health Svs			X
	CM Office Visit Client	Medical Case Management	X	X	
	CM Community Visit Client	Medical Case Management	X	X	
	CM Collateral	Medical Case Management	X	X	
	CM Non Face to Face Client	Medical Case Management	X	X	
	CM Failed Attempt at Contact	Medical Case Management	X	X	
Optional	CM Service Plan Completed/Reviewed	Medical Case Management	X	X	
Optional	CM Assessment Completed/Reviewed	Medical Case Management	X	X	
Optional	CM Eligibility Reassessment Complete	Medical Case Management	X	X	
Optional	CM Viral Load Data Entry/Reviewed	Medical Case Management	X	X	
	Title XIX U8 Billable	Medical Case Management	X	X	
	Title XIX U9 Billable	Medical Case Management	X	X	
	Title XIX CA Billable	Medical Case Management	X	X	
	OUTREACH				
	Outreach Face to Face Client	Outreach Services	X	X	
	Outreach Non Face to Face Client	Outreach Services	X	X	
	Outreach Collateral	Outreach Services	X	X	
	Outreach Failed Attempt at Contact	Outreach Services	X	X	
	PSYCHOSOCIAL				
	Psychosocial Session	Psychosocial Support Services	X	X	
	MENTAL HEALTH				
	MH Individual Session	Mental Health Services	X	X	
	MH Group Session	Mental Health Services	X	X	
	SUBSTANCE ABUSE				
	SA Assessment Completed/Reviewed	Substance Abuse Services Outpatient (outpt)	X	X	
	SA Individual Session	Substance Abuse Services outpt	X	X	
	SA Group Session	Substance Abuse Services outpt	X	X	
	MEDICAL TRANSPORTATION				
	MT Voucher Gas	Medical Transportation Services	X	X	
	MT Voucher Bus	Medical Transportation Services	X	X	
	MT Voucher Ferry	Medical Transportation Services	X	X	
	Mt Voucher Taxi	Medical Transportation Services	X	X	
	FOOD BANK/HOMEDELIVERED MEALS				
	FM Voucher Food/Meals	Food Bank/Home Delivered Meals	X	X	
	FM Grocery Bag	Food Bank/Home Delivered Meals	X	X	

	Sub-Service Name	RSR Service Category	DOH Engagement	DOH Retention	HAB Measure
	FM Nutrition Supplements	Food Bank/Home Delivered Meals	X	X	
	FM Essential Items Bag	Food Bank/Home Delivered Meals	X	X	
	HOUSING				
	DOH Housing Rent	Housing Services	X	X	
	DOH Housing Shelter	Housing Services	X	X	
	DOH Housing Motel	Housing Services	X	X	
	DOH Housing Utilities	Housing Services	X	X	
	DOH Housing Application Fee	Housing Services	X	X	
	DOH Housing Deposit	Housing Services	X	X	
Optional	DOH Housing Service Plan Completed/Reviewed	Housing Services	X	X	
	LINGUISTICS				
	Interpretation Services	Linguistics	X	X	
	Translation Services	Linguistics	X	X	
	HEALTH EDUCATION RISK REDUCTION				
	HE/RR Services	Health Education/Risk Reduction	X	X	
	EARLY INTERVENTION SERVICES				
	EIS Targeted Testing	Early Intervention Services	X	X	
	EIS Referral to Case Management	Early Intervention Services	X	X	
	EIS Referral to PrEP	Early Intervention Services	X	X	
	EIS Referral to Medical Care	Early Intervention Services	X	X	
	EIS Linkage to Case Management	Early Intervention Services	X	X	
	EIS Linkage to PrEP	Early Intervention Services	X	X	
	EIS Linkage to Medical Care	Early Intervention Services	X	X	
	EIS HE/RR	Early Intervention Services	X	X	
	EIS Outreach Client Level	Early Intervention Services	X	X	
	EIS F/F Visit Client Level	Early Intervention Services	X	X	
	EIS non F/F Visit Client Level	Early Intervention Services	X	X	

Data

	Early Intervention Services	Outreach Services	Case Management	Food Bank or Home Delivered Meals	Health Education or Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Mental Health Services	Psychosocial Services	Substance Abuse Services
Demographics											
First Name	•	•	•	•	•	•	•	•	•	•	•
Middle Name	optional	optional	optional	optional	optional	optional	optional	optional	optional	optional	optional
Last Name	•	•	•	•	•	•	•	•	•	•	•
Date of Birth			•	•	•	•	•	•	•	•	•
Gender	•	•	•	•	•	•	•	•	•	•	•
Sex at Birth	•	•	•	•	•	•	•	•	•	•	•
Physical Address (document if homeless)		•	•	•	•	•	•	•	•	•	•
City	•	•	•	•	•	•	•	•	•	•	•
State	•	•	•	•	•	•	•	•	•	•	•
Zip Code	•	•	•	•	•	•	•	•	•	•	•
County	•	•	•	•	•	•	•	•	•	•	•
Phone Number	optional	optional	optional	optional	optional	optional	optional	optional	optional	optional	optional
HIV Status											
HIV Status	if applicable	•	•	•	•	•	•	•	•	•	•
HIV Positive Date	if applicable	•	•	•	•	•	•	•	•	•	•
AIDS Date	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable
HIV Risk Factor	if applicable	•	•	•	•	•	•	•	•	•	•

Data

	Early Intervention Services	Outreach Services	Case Management	Food Bank or Home Delivered Meals	Health Education or Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Mental Health Services	Psychosocial Services	Substance Abuse Services
Program Eligibility											
Eligibility Status			•	•	•	•	•	•	•	•	•
Vital Status			•	•	•	•	•	•	•	•	•
Deceased Date			if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable
Enrollment Date			•	•	•	•	•	•	•	•	•
Case Closed			if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable
Annual Review											
Primary Insurance			•	•	•	•	•	•	•	•	•
Other insurance			if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable	if applicable
Housing/Living arrangement			•	•	•	•	•	•	•	•	•
Household size			•	•	•	•	•	•	•	•	•