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# **Ryan White Part B HIV Community Services Provider Manual**

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## **Implementing HIV Community Service Programs in Washington State**

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**Office of Infectious Disease**

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DOH 410-080 March 2021

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## Terminology

This manual contains terminology and acronyms that are specific to the HIV Community Services (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 Corrections (DOC) is the agency that manages all state-operated adult prisons and supervises adult inmates who live in the community.

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.

Disease Intervention Specialist (DIS) are public health outreach workers who are responsible for finding and counseling people with sexually transmitted diseases and their contacts.

Early Intervention Services (EIS) are a combination of services that include identification of individuals to help the unaware learn of their HIV status and receive referral to HIV care and treatment services.

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 – HIV Community Services.

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.

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.

Syndemic is a set of linked health problems involving two or more afflictions, interacting synergistically, and contributing to excess burden of disease in a population. Syndemics occur when health-related problems cluster by common social under-pinnings.

# How to Use this Manual

## 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 health outcomes - through the implementation of performance measurements and quality management methods including monitoring, evaluation, and improvement activities.
8. **Appendix:** Provides relevant, useful resources.

## 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

- At OID we prioritize the lens of “Leading with Equity” to serve PLWH, our sub-recipients, and our interactions with each other.
- HIV Community Services are delivered with a trauma-informed approach.
- 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 to collectively promote the general health and welfare of the community served.

### HIV Community Services

HCS contracts with community partners to provide case management and other support services. These services include case management, substance use outpatient 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

## Overview

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).

HRSA develops policies that implement the legislation, providing guidance to recipients in understanding and implementing legislative requirements. These policies provide additional guidance and can be referenced at the website listed below:

- <https://hab.hrsa.gov/program-grants-management/policy-notice-and-program-letters>



### Leading with Equity

Equity and social justice are integral to ending the HIV epidemic. HIV is as much a social and developmental disease as a medical one. HIV-related health disparities do not exist in isolation. They are part of a larger system of inequities people living with HIV (PLWH) experience daily. The Office of Infectious Disease (OID) within the Washington Department of Health (DOH) recognizes we play an important role in identifying and proposing strategies that intentionally work to reduce disparities and promote equity. It is our intent to lead with equity. However, it is our belief that achieving this requires a paradigm shift. It requires a social justice approach that looks not only at specific indicators of inequality, but also attempts to address issues broadly associated with the social determinants of health.

Health disparities are inextricably linked to a complex blend of social determinants that influence populations most severely affected by this disease. Health equity is a desirable goal that requires an intentional focus on improving health outcomes for those experiencing social or economic disadvantage. Social determinants of health affect disparities in the syndemic of HIV, viral hepatitis and sexually transmitted diseases. Environmental factors such as housing conditions, social networks, and social support are also key drivers for acquisition and transmission of the syndemic. It is our intent to ensure case management services are implemented in ways that are informed by all of these factors.

Racism has played a unique role in the health and well-being of many people living with HIV. Fighting health inequity means fighting against racism. BLACK LIVES MATTER. BLACK TRANS LIVES MATTER. Events including the killings of Michael Brown, Tamir Rice, Eric Garner, Philando Castile, George Floyd, Breonna Taylor, Manuel Ellis, Tony McDade, James Scurlock, Dominique Fells, Riah Milton, Rayshard Brooks and Ahmaud Arbery testify to the racial injustice that persists across our country and within our communities. We share in the outrage and anguish expressed around the United States in response to the treatment of Black Americans by the police and the toll of police killings. Moreover, similar injustices are pervasive in many other parts of the world. While these killings highlight inequities inherent in the criminal justice system. Similar inequities exist in public health, health care, social welfare, education and economic systems. Institutional racism is pervasive and endemic.

Ending the syndemic requires us to examine our current HIV service delivery system with the goal of eliminating policies, practices, ideas, and behaviors that give an unjust amount of resources, rights, and power to white people while denying them to people of color.

# Overview

## Trauma Informed Approach

### TRAUMA-INFORMED & EQUITY AND SOCIAL JUSTICE INTERSECTIONS



According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 70% of PLWH have experienced trauma, and PLWH are twenty times more likely to have experienced trauma when compared to the general population. These traumatic experiences have social, behavioral, economic, and health consequences which are disproportionately experienced by PLWH (NASTAD, 2018).

Recognizing and responding to the impacts of trauma, working to reduce re-traumatization, and aiming to recognize strengths and resiliency will result in better care and improvement in the health of PLWH and staff providing care for PLWH.

### Types of Trauma and Definitions

**Acute:** An event or experience that occurs at a particular time/place and is short lived.

**Chronic:** Events or experiences that occur repeatedly over long periods of time. May include one or multiple forms.

**Historical:** Refers to the negative impacts of group trauma across generations still suffering its effects.

### SAMHSA Trauma Informed Approach

A program, organization, or system that is trauma-informed:

## Overview

- Realizes the widespread impact of trauma and understands potential paths for recovery.
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization.

### Trauma Informed Care Standards

The following standards have been developed in order to work towards a trauma-informed system across subrecipients.

Policy	Standards
<p>Adoption of trauma informed culture—values, principles and development of a trauma-informed organization ensuring safety and preventing re-traumatization.</p>	<p>Subrecipients shall ensure that all staff is trained/has ongoing training in trauma-informed organizational practices. Staff trained in trauma informed organizational practice should:</p> <ul style="list-style-type: none"> <li>• understand what trauma is and the principles of trauma-informed culture;</li> <li>• know the impact of trauma on a child’s and thus, an adult’s life;</li> <li>• know strategies to mitigate the impact of the trauma(s); and</li> <li>• understand re-traumatization and its impact.</li> </ul> <p>Subrecipients policies and procedures shall ensure that a trauma informed system is supported and the policies address trauma issues, re-traumatization and secondary trauma of staff.</p> <p>Subrecipients shall aim to create a safe physical and social-emotional environment for PLWH and staff. Examples may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• keeping parking lots, common areas, bathrooms, entrances well lit;</li> <li>• keeping noise levels in waiting rooms low;</li> <li>• using welcoming and inclusive language on all signage;</li> <li>• ensuring staff maintain healthy interpersonal boundaries;</li> <li>• maintaining communication that is consistent, open, and respectful;</li> <li>• awareness of how an individual’s culture affects how they perceive trauma and safety.</li> </ul>
<p>Engagement in organizational self-assessment of trauma-informed strategies.</p>	<p>Subrecipients conduct an organizational self-assessment to evaluate the extent to which current agency’s policies are trauma-informed and identify organizational strengths and</p>

## Overview

	<p>barriers to ensure that the environment does not re-traumatize. The self-assessment is updated every three (3) years. A sample self-assessment tool is included in <a href="#">Appendix A</a>, however, agencies may elect to use/create their own tool.</p>
<p>Adoption of approaches that prevent and address Secondary Trauma of staff.</p>	<p>Subrecipients shall adopt approaches that prevent and address secondary traumatic stress of staff. These may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Opportunities for supervision</li> <li>• Trauma-specific incident debriefing</li> <li>• Training</li> <li>• Encouraging self-care and physical activity</li> <li>• Other organizational support (e.g., employee assistance program)</li> </ul>
<p>Adoption of PLWH Involvement.</p>	<p>Subrecipients shall aim to include input from PLWH whenever applicable. Examples might include:</p> <ul style="list-style-type: none"> <li>• Peer navigation</li> <li>• CAB meetings</li> <li>• Quality improvement</li> </ul>

### *Citations and Resources*

SAMHSA's Trauma and Justice Strategic Initiative (2014, July). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Retrieved from <https://store.samhsa.gov/system/files/sma14-4884.pdf>.

# UNIVERSAL STANDARDS

## 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. These standards align with Health and Human Services Standards. For more information, visit:

<https://hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf>

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 Universal Standards tables is as follows:

<b>Standard</b>	<b>Documentation</b>
Minimum requirement that DOH expects programs to meet when providing services.	Appropriate documentation required.

# Universal Standards—Eligibility

## 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

Due to the higher cost of living (including housing and transportation costs) that Washington State is experiencing in urban areas such as Seattle, Tacoma, Spokane, and Vancouver, the maximum income qualification for Case Management Services is currently set at 750% FPL. This ensures that clients needing a safety net to Ryan White support services will have continuous access to Case Management. An HCS provider must collect income information, including Household Income and Household size, for all case managed clients within thirty (30) days of initiating intake.

To establish eligibility, providers must document and verify the following information:

- 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

Eligibility Requirement	Examples of Acceptable Documentation
HIV or AIDS Diagnosis	<ul style="list-style-type: none"> <li>• Positive ELISA with confirming Western Blot test results</li> <li>• RNA-PCR or Branched DNA test showing detectable viral load of HIV virus</li> <li>• Original lab report indicating HIV positive status (e.g. lab report showing detectable viral load, med list)</li> <li>• Letter, with signature from MD, ARNP, or PA stating client is HIV positive</li> <li>• HIV Viral Load Test in Data Management System</li> </ul>
Washington State Residency	<ul style="list-style-type: none"> <li>• Unexpired Washington state driver license or Tribal ID</li> <li>• Unexpired Washington state ID</li> <li>• Washington state voter registration card</li> <li>• Utility bill (cell phone bills not accepted)</li> <li>• Lease, rental, mortgage, or moorage agreement/document</li> <li>• Homeless client statement</li> <li>• Award letter from SSI or SSDI with clients address on it</li> <li>• ACES printout (client must be actively receiving services)</li> <li>• DOC ID</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>• A signed letter from a person with whom the client resides or who otherwise provides housing for the applicant.</li> </ul>

## Universal Standards—Eligibility

	<ul style="list-style-type: none"> <li>• A signed letter from a case manager, or other professional explaining why the client’s claim of Washington residency is supportable.</li> <li>• 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.</li> </ul>
Income of client and all applicable household members	<ul style="list-style-type: none"> <li>• Check/pay stub (must show name, pay period, and gross income received)</li> <li>• Unemployment stub</li> <li>• Monthly benefit statement</li> <li>• Annual benefit statement Employer W-2</li> <li>• Profit &amp; loss statement</li> <li>• Copy of SSI or SSDI statement</li> <li>• Self-Employment Income Statement (in conjunction with a bank statement) No Income Statement</li> </ul>
Health Coverage Status	<ul style="list-style-type: none"> <li>• Medical or dental insurance card</li> <li>• Medicare/Medicaid Statement</li> </ul>

### Reassessment of Eligibility

For all 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.

HCS provider must collect information on household income and size every six (6) months. The provider can obtain this through client attestation.

## 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 be 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 (due to the COVID-19 pandemic, verbal signatures with Progress Log are permitted).

### 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.

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



# Universal Standards—Confidentiality

## Standards

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

Standard	Documentation
<p>HCS providers will protect confidentiality in accordance with state and federal laws.</p>	<ul style="list-style-type: none"> <li>• HCS provider’s confidentiality policy is available for inspection and is in accordance with state and federal laws.</li> <li>• HCS provider posts their confidentiality policy in an area(s) readily visible to clients.</li> <li>• 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.</li> </ul>
<p>A Client Release of Information Form must exist describing under what circumstances the provider can release client information.</p>	<ul style="list-style-type: none"> <li>• HCS provider has a signed Release of Information in each client record that includes all the required elements.</li> <li>• ROI articulates parameters of information sharing with funder(s) for the purpose of compliance audits.</li> </ul>
<p>All staff and volunteers will sign a statement agreeing to the subrecipient’s confidentiality policy.</p>	<ul style="list-style-type: none"> <li>• HCS provider has a signed staff Confidentiality Agreement for each staff and volunteer.</li> </ul>
<p>Provider must have a policy on storing hard copies, as well as electronically stored client information.</p>	<ul style="list-style-type: none"> <li>• Provider’s information storage policy is available for inspection.</li> <li>• Provider stores records in locked file, cabinet, or room.</li> <li>• Electronic files are password protected with access limited.</li> </ul>
<p>Service providers must have a policy for retaining client records, as well as for destroying records that pass the retention date.</p>	<ul style="list-style-type: none"> <li>• HCS provider has a record retention policy. Records are stored and accessible for a period of six years after the closing date.</li> </ul>

# Universal Standards—Client’s Rights and Responsibilities

## 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’s 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 living with HIV. Agencies must comply with the Americans with Disabilities Act (ADA) ([www.ada.gov/](http://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.

# Universal Standards—Client’s Rights and Responsibilities

## 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

# Universal Standards—Client’s Rights and Responsibilities

## Standards

**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	Documentation
HCS provider will ensure that clients are aware of and understand their rights and responsibilities as consumers of HIV services.	HCS providers’ Client Rights and Responsibilities Statement is signed and dated by client.
There will be no barriers due to client disability.	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.	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.	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.	HCS provider has a Nondiscrimination Policy and maintains record of individuals refused services with: <ul style="list-style-type: none"> <li>• Reasons for refusal specified</li> <li>• Complaints from client</li> <li>• Complaint review</li> <li>• Decision reached</li> </ul>

# Universal Standards—Grievance Policy

## 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	Documentation
HCS provider will provide a process to address client grievances.	<ul style="list-style-type: none"><li>• HCS provider has a written grievance policy.</li><li>• Provider logs all grievances.</li><li>• Notes regarding subsequent investigations, findings, and actions are available for inspection/review</li></ul>

# Universal Standards—Transition or Discharge

## 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	Documentation
HCS provider will ensure continuity of services for all clients to the best of their ability.	<ul style="list-style-type: none"><li>• HCS provider has a written transition and discharge policy.</li><li>• Transition or discharge procedures include:<ul style="list-style-type: none"><li>o Steps a client must follow to transition to another subrecipient</li><li>o Steps the subrecipient must follow to transition or discharge a client.</li></ul></li><li>• A client’s right to appeal.</li><li>• Provider logged all transitions and discharges.</li><li>• Notes regarding subsequent investigations, findings, and actions are available for inspection.</li></ul>

# Universal Standards—Culturally and Linguistically Appropriate Services (CLAS)

## Culturally and Linguistically Appropriate Services (CLAS)

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.

The CLAS standards are not a law, but they have strong legal connections to [Title VI of the Civil Rights Act](#). Full adoption and implementation of the CLAS Standards helps an agency or organization comply with Title VI and other federal laws.

There are 15 CLAS Standards. Standards 2-14 serve as do-able steps to achieve the principal standard. [Print a copy for your records \(PDF\)](#).

### Principal Standard

1. Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

### Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in that area.
4. Education and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

### Communication and Language Assistance

5. Offer language assistance to individuals who have Limited English Proficiency (LEP) and/or other communication needs at no cost to them, to facilitate timely access to all healthcare and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand printed and multimedia materials and signage in the languages commonly used by the populations in the service area.

### Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measures and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

## Universal Standards—Culturally and Linguistically Appropriate Services (CLAS)

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

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

Standard	Documentation
<p>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.</p>	<p>HCS provider documents access to services with limited English skills through the following:</p> <ul style="list-style-type: none"> <li>• Bilingual staff: resumes on file demonstrating bilingual proficiency and documentation on file of training on the skills and ethics of interpreting.</li> <li>• Contract or volunteer interpreters: copy of certifications on file.</li> <li>• Telephone interpreter services: listings on file</li> <li>• Family or friend interpreter services: consent form signed by client and maintained in client file.</li> </ul>
<p>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.</p>	<p>HCS provider has a written Cultural Competency policy.</p>



# Universal Standards—Records Management and Reporting

## 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 the DOH database to track activities, enter progress logs, 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 data summaries in lieu of providers submitting quarterly demographic data. Providers must submit aggregate population based PAHR data quarterly.

Providers must submit reports 30 days after the end of quarter. If the due date falls on a weekend or holiday, the report can be submitted on the Friday before or Monday after.

Quarter One: January 1– March 31  
Quarter Two: April 1– June 30  
Quarter Three: July 1– September 30  
Quarter Four: October 1– December 31

Report Due: April 30  
Report Due: July 30  
Report Due: October 30  
Report Due: January 30

## Personnel

### Skills and Knowledge

HCS personnel must have appropriate credentials under the laws and regulations of the state of Washington or should demonstrate enough 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

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 DOH

HSC personnel must have:

- Clear and updated job descriptions
- An orientation
- Supervision
- Appropriate ongoing training opportunities

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

# Universal Standards—Personnel

## 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. In addition, DOH funded staff must receive a minimum of 20 hours of job-related trainings per year (DOH sponsored training will count towards the 20 hours minimum, at 8 hours per day of training). 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 HCS personnel 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 Humility
- HIV Treatment and Trends
- Tobacco Cessation
- HIV Prevention
- Harm Reduction
- Retention in Care Training (ARTAS)

## Universal Standards—Personnel

- Ethics
- Motivational Interviewing (MI)

### 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.

# Title XIX Medical Case Management

## 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—The services provided must be documented in the DOH database and must match 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

## Title XIX Medical Case Management

- 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 one 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 management and program evaluation purposes.

### HCA Case Management Billing Guide

The guide is available at [www.hca.wa.gov/assets/billers-and-providers/HIV-bi-20190101.pdf](http://www.hca.wa.gov/assets/billers-and-providers/HIV-bi-20190101.pdf).

## PLWH Core Medical and Support Services Standards

### RWHAP Core Medical Services

- AIDS Drug Assistance Program Treatments
- AIDS Pharmaceutical Assistance
- Early Intervention Services (EIS)
- Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals
- Medical Case Management
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

### RWHAP Support Services

- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health Education/Risk Reduction
- Housing
- Legal Services
- Linguistic Services
- Medical Transportation
- Non-Medical Case Management Services
- Outreach Services

Service standards outline the elements and expectations a HCS provider follows when implementing a specific service category. The purpose of service standards is 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.

The standards are in the format below. Review the format and refer 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.

# PLWH Core Medical and Support Services Standards

**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 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.

<b>Standard</b>	<b>Documentation</b>
Minimum requirement that DOH expects programs to meet when providing services.	Appropriate documentation required.



## AIDS Drug Assistance Program (ADAP)

### Early Intervention Program (EIP)

EIP directly pays for prescription medication coverage, medical care, insurance premium payment assistance, insurance co-pays, dental services, and mental health services. Washington's AIDS Drug Assistance Program (ADAP) is part of EIP.

To be eligible for EIP a person must:

- Be living with HIV.
- Live in Washington State.
- Have family income at or below 425% 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.
  - 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 without insurance
  - d. EIP has an open formulary for PLWH who are insured. If the medication is on the primary insurance's formulary, EIP will pay the co-pay.
  - e. 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.

## ADAP & EIP

5. Dental Services
  - a. EIP pays for 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. Effective January 2021, there is a \$3000 cap on covered dental services.
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.
7. Medicaid Dental and Mental Health Waivers
  - a. EIP covers dental services not traditionally covered for clients on Medicaid, allowing clients to utilize EIP's Covered Dental Services list in tandem with the services they qualify for through Medicaid.
  - b. EIP will provide eligibility and coverage for mental health services if a Medicaid client cannot access a mental health provider through Medicaid.
  - c. A PLWH must work with a Case Manager to submit a Medicaid waiver along with an EIP application for coverage.
  - d. To receive coverage, eligible clients must go to an EIP contracted provider for EIP covered dental or mental health services.

### Link to EIP Services:

- [www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP](http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP)

## 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,

# Case Management

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

## Support services

For those clients receiving support services, such as transportation assistance, food vouchers, or housing assistance, 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.
- Prioritize medical engagement/retention, viral suppression, and stable housing as recognized indicators of positive health outcomes and quality of life.
- Utilize client centered, strengths-based 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
- 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

- 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

## Standards for 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.

Standard	Documentation
<p>Case Management records will reflect compliance with the Case Management Standards of Care. Records must be complete, accurate, confidential, and secure.</p>	<ul style="list-style-type: none"> <li>• Case Management records include:               <ul style="list-style-type: none"> <li>o Date of client visit or contact</li> <li>o Reason for visit or contact</li> <li>o Activities performed</li> <li>o Outcome</li> <li>o Follow-up plan</li> <li>o Documentation that client meets eligibility criteria</li> </ul> </li> <li>• Using DOH Data System, HCS provider documents Case Management services in progress logs with corresponding service units.</li> </ul>
<p>HCS providers must be able to provide quantified program reporting activities.</p>	<p>Provider is able to report on Performance Indicators and Outcome Measures.</p>

# Case Management

## 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 is needed, to establish the client's 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 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.

# 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 assistants must document that the client received, or staff offered a copy of, and understood, all of the above documents. Client must sign and date this document.

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 HCA 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 assistants 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, and 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 assistants should prioritize helping clients gain or maintain access to medications.

# Case Management

## Standards

Standard	Documentation
<p>HCS will set intake within two (2) weeks of client stated interest in establishing services with HCS provider.</p>	<ul style="list-style-type: none"> <li>• HCS provider documents the date of first contact by or with client.</li> <li>• HCS provider documents the date of intake appointment.</li> </ul>
<p>HCS will complete intake within two (2) weeks of initiation.</p>	<ul style="list-style-type: none"> <li>• HCS provider documents the date intake began and date intake was completed.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• HCS provider documents the date they received the referral and the date they acted upon the referral.</li> </ul>
<p>HCS provider will share and explain the following Policies and Procedures to all clients within thirty (30) days of initiation of services:</p> <ul style="list-style-type: none"> <li>• Obtain consent for case management services</li> <li>• Explain the subrecipient’s eligibility policy</li> <li>• Explain the subrecipient’s confidentiality policy</li> <li>• Explain the subrecipient’s client rights and responsibilities policy</li> <li>• Explain the subrecipient’s grievance policy</li> <li>• Explain subrecipient’s reassessment of eligibility policy</li> <li>• Explain the subrecipient’s transition/discharge policy</li> <li>• Explain client’s freedom to choose a provider</li> </ul>	<ul style="list-style-type: none"> <li>• HCS provider documents that client received and understood all relevant Policies and Procedures.</li> <li>• Documentation includes date and signature by client attesting to both receipt and comprehension of Policies and Procedures.</li> <li>• Date on attestation is within thirty (30) days of initiation of services.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The ROI includes language identifying DOH (and HCA where applicable) as one of the entities with whom information may be shared for purposes of monitoring and assessing quality, program, or fiscal compliance.</li> </ul>
<p>HCS provider will obtain permission from DOH to use any Intake document other than the combination Intake/CA form provided by WA DOH.</p>	<ul style="list-style-type: none"> <li>• HCS documents that DOH approved alternative intake form.</li> </ul>



# Case Management

## Comprehensive Assessment (CA)

**Purpose:** 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 and life domain status to determine the clients' needs across life domains.

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
  - HIV-related
  - Justice Involvement
  - 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

Case management agencies must use the Washington State Department of Health's comprehensive assessment unless the HIV Community Services Supervisor or the Statewide Case Management Coordinator grants a waiver. The Washington State Department of Health worked extensively with case

# Case Management

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.

## Comprehensive Assessment Timeline

Case managers must begin and complete a Comprehensive Assessment within the following timeframe:

- A Comprehensive Assessment must be completed within 30 days of completing intake
- Completion of a Comprehensive Reassessment if there is a significant (more than 50%) change in life domain stability/activity

## Standards

Standard	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.	The client record documents a completed assessment form covering the following: <ul style="list-style-type: none"> <li>• Medical</li> <li>• Mental health</li> <li>• Substance use</li> <li>• Psychosocial needs</li> <li>• HIV risk behaviors</li> <li>• Food</li> <li>• Housing</li> <li>• Insurance</li> <li>• Self-Efficacy</li> <li>• Legal</li> <li>• Adherence</li> <li>• Employment/Financial</li> <li>• Cultural/Linguistic</li> <li>• Prevention/Education</li> </ul>
HCS provider completes CA within thirty (30) days of completion of intake.	HCS provider completed CA.
HCS staff completing the CA will sign and date the document.	HCS staff signature and date on CA.
HCS staff completes Comprehensive Reassessments every five (5) years.	HSC provider documents completed Comprehensive Reassessment at appropriate intervals.

# Case Management

HCS staff completes Comprehensive Reassessments at 50% change in life domain status/activity for all clients.

HSC provider documents when they completed Comprehensive Reassessment.

# Case Management Standards

## Individualized Service Plan (ISP) Standards

The purpose of these standards is to ensure that case management staff create an ISP that:

- is client-centered and client-voiced;
- can be completed in a timely manner;
- links the ISP to the CA; and
- includes an action plan that meets client's needs and goals.

## Timeline

Case management staff must:

- complete and sign ISP within 2 weeks of completing the CA; and
- reassess ISP for clients every six (6) 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. Electronic signatures are permitted.

### 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; and
- 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

# Case Management Standards

the ISP and establish new goals. Case managers must conduct an interim reassessment utilizing the ISP every six (6) months for all clients.

## Standards

Standard	Documentation
HCS provider develops, uses, and reassesses the ISP jointly with the client.	There is documentation in client chart of ISP that includes: <ul style="list-style-type: none"> <li>• client initiated goal &amp; action steps;</li> <li>• persons responsible, measurements of success;</li> <li>• signed and dated by both Client and HCS staff.</li> </ul>
ISP links to the Comprehensive Assessment.	There is documentation in client chart of ISP elements that link to CA.
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 updates ISP as clinically appropriate or at minimum every six (6) months.	There is documentation in client chart of updates to service plan.

# Case Management Standards

## Service Plan Implementation

**Purpose:** 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.

## Progress Logs

Progress Logs 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 progress log the reason for the case manager's interaction with or on behalf of the client and what services they provided. If billing Title XIX, case managers must complete a progress log within every billing cycle, and the progress log must match the month billed.

In completing progress logs, case management staff must follow these guidelines:

- Document chronologically
- Be entered into DOH database 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
  - 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 A signed progress log 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 progress log author as well

# Case Management Standards

## Progress Log Best Practices

Progress logs 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. Records must be complete, accurate, confidential, and secure. Unless worksite specific documentation styles are prescribed, Case Managers will use the DDAP model in Provide. DDAP stands for Domain, Data, Assessment, and Plan. The following is specific to how it is used by Case Managers when inputting a Progress Log:

### Domain

Identify the domain or domains primarily addressed during the interaction. Consider connection to the ISP whenever possible. You can think of this also as the space for identifying "Needs". Examples:

- **Support System:** achieve and maintain an adequate support system
- **Cultural/Linguistic:** meet cultural/linguistic needs
- **Medical:** maintain consistent medical care and access
- **Adherence:** maintain consistent adherence to prescribed medications
- **Mental Health:** access mental health services and support as needed
- **Basic:** utilize services as appropriate to meet basic needs
- **Income:** have access to employment and income related services as appropriate
- **Housing:** maintain stable and adequate housing
- **Transportation:** have access to transportation for HIV-related needs
- **Self-Efficacy:** maintain and increase self-sufficiency
- **Prevention:** have access to education and prevention supplies and support as needed/requested
- **Substance:** access substance use treatment and/or recovery support as needed
- **Legal:** complete legal documents as needed/requested
- **Insurance:** maintain consistent insurance coverage
- **Dental:** maintain consistent dental care and access

### Data

Capture the general or overall content of the interaction, including subjective and objective data on the client. Limit to the relevant. Appropriate, professional language only; remember we are strengths-based. Call out specific interventions.

### Assessment

Express your understanding of the problem(s), client response to interventions so far, identified current or possible barriers to success. Can include observations of presentation as well as orientation to person, place, time and situation. Strengths and deficits relevant to goals and objectives being addressed may also be included.

### Plan

Articulate next action steps, identifying the responsible party: referrals, coordination of care, behavior modification, next appointment, etc. Be thorough even while being concise. "Continue to support," or "Follow up as appropriate," are insufficient.

# Case Management Standards

**Documentation is equally important to service delivery.** It provides a narrative that can support the work of a care team while supplying data to support the efficacy of services.

Example of adequate progress logs:

D: Insurance/EIP

D: CM left message for client that his EIP does not expire for two more months, on 7/31/2019. CM explained his renewal would typically be done late June/early July.

A: N/A

P: CM advised client to call if he has questions. CM will follow up with client on (date) to schedule EIP renewal.

JD, MCM

D: Client crisis

D: Client came in to office needed assistance with mental health needs. Looked at therapists with client and gave them contact information for them. Submitted EIP application with client and submitted Medicaid Waiver.

A: Client's spouse left them and client presented distressed and crying. They need someone to talk to. Client seemed excited to start seeing a therapist soon.

P: CM will check status of Medicaid Waiver submitted to EIP on (date) and contact client to let them know when it is approved. Will follow up with client at that time to see if there is any other assistance they need.

JD, MCM



## 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 whom the client may be working with
- 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 themselves
- 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



## Case Management Standards

- 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.

# Case Management Standards

## Case Closure

**Purpose:** 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
- 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 progress log in the DOH database.

A transition summary must include the following elements:

- Date of last successful contact with client
- Most recent viral load date and value of client
- Most recent HIV-related medical care visit
- Reason for transition (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.

# Case Management Standards

If the client is transitioning to another case management agency within Washington state, and with the proper ROI in place, the case manager must refer the client to the new case management agency in the DOH database. To ensure a warm handoff, the case manager last working with the client should attempt to verify that the new case management agency has received the referral and is providing case management services to client.

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 progress log in the DOH database.

At minimum, a discharge summary should include the following elements:

- Date of last successful contact with client
- Most recent viral load 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
- Date of outreach to jail services and DOC where appropriate
- Name and contact information of jail services or DOC personnel contacted
- Expected date of release, if available
- Confirmation that a plan around medications is in place with jail services, if needed

## Case Management Standards

Reason for Closure	Type of Service	Type of Summary	DOH database 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 suspected in care	Lost to Care	Discharge	Referral/Discharge
Lost to Care suspected not in care	Lost to Care	Lost to Care	Referral/Discharge

### Standards

Standard	Documentation
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 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.

# Case Management Standards

## 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. 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 clients who are not virally suppressed or would otherwise be considered high acuity, this would mean the second month of no contact (i.e. no contact in March begin outreach and reengagement in April). For clients who have maintained viral suppression or would otherwise be considered 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).

In addition to viral suppression, clients’ unmet needs and other barriers to engagement in care, must be taken into consideration when determining acuity. These unmet needs/barriers should be identified upon completion of the comprehensive assessment. Examples can include: a client that is virally suppressed but unstably housed or a client that is virally suppressed but newly diagnosed with HIV. Although the client is virally suppressed, there are vulnerabilities in other areas of their life that could impact their ability to remain virally suppressed and medically managed. A client centered approach is encouraged in all cases.

See [Appendix B](#) for the Lost to Care flow chart that outlines the outreach process. DOH asks that outreach and reengagement attempts exhaust all allowable methods of contact. This could include telephone, email, text, mail, and in person outreach. Outreach should also include contacting emergency contacts and collaborative professionals, such as medical providers, pharmacies, housing programs, and so forth where allowable. All successful and unsuccessful contact attempts must be documented in a case note in the Provide database. Case managers should reach out to the DOH HIV Case Management Coordinator if there is uncertainty on how to proceed or if a client situation is not adequately represented in the flow chart.

For clients who appear to be Lost to Care or falling out of care, DOH requests HCS providers alert DOH to the possibility of a “Lost to Care” client after they have made reasonable attempts by all ROI-allowable methods, to contact and reengage the client. The provider can do this by contacting the DOH HIV Case Management Coordinator through a secure message in Provide. The HIV Case Management Coordinator will determine if criteria are met to refer this to the DOH Data-to-Care Coordinator. The Data-to-Care Coordinator will search for locating information for the client from all available sources to determine if the client still resides in Washington, has moved to another jurisdiction within Washington, or has relocated out of state. They will also look for recent lab results or other evidence that the client remains engaged in care or case management elsewhere. Updates on the client will be relayed back to the Case Manager. If the Data-to-Care Coordinator is unable to find additional information or determine whether the client is engaged in care, the client will be referred to DOH for further investigation. If case management staff suspect that a client has relocated or are unable to complete contact attempts with the contact information on file, they should notify the DOH Data-to-Care Coordinator early on to assist in looking for new locating information.

## Case Management Standards

If the Data-to-Care Coordinator is unable to identify whether the client is currently engaged in care, the client will be referred to DOH for further investigation. If the client appears truly out of care, DOH will initiate the investigation process and the Lost to Care work group will collectively strategize on the best approach to reengage the client. If Case Management staff are unable to find someone or are running into barriers locating a client, they can reach out to the Data-to-Care coordinator early in the process to obtain the most recent locating information for the client.

As clients move through this 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 the 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 Contact” label under Care Tab- Service Category in the Provide database.

### 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 ISP.

### Lost to Care Process Complete and Client not deemed “out of care”:

If DOH completes the Lost 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 in the Provide database. 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 progress log in the DOH database. The summary must include:

- Date of last successful contact with client
- Most recent viral load 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.

## Case Management Standards

The HCS provider must complete a Lost to Care summary case note in the DOH database. Lost to Care summary must include the following:

- Date of last successful contact with client
- Most recent viral load 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

## 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:

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

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.
- Treatment as Prevention (Undetectable=Untransmittable).

EIS has three subcategories: HIV Testing and Counseling, Linkage to Care, and Retention in Care. Not all providers of Linkage to Care need provide HIV Testing and Counseling nor they need to provide Linkage to Care. However, providers must seamlessly link these types of services if they are 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* (EIS – PAHR) 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 clients learn to assimilate their diagnosis. This helps them understand:

- The implications of an HIV diagnosis for themselves and others.
- Opt for appropriate care and services.



## Early Intervention Services

- Commit to a regimen that enhances their 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 receive 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.

### Standards

#### Eligibility

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

Standard	Documentation
EIS are for persons who are unaware of their HIV status or are positive and out of care.	<ul style="list-style-type: none"> <li>• HCS provider has documentation that client needs Early Intervention Status.</li> </ul>
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.	<ul style="list-style-type: none"> <li>• HCS provider has documentation of client FPL.</li> </ul>
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.	<ul style="list-style-type: none"> <li>• HCS provider has documentation of Washington State residency.</li> </ul>
For clients who are HIV positive and out of care, eligibility for services will include client is HIV positive.	<ul style="list-style-type: none"> <li>• HCS provider has documentation of HIV status.</li> </ul>

#### Service Coordination

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

Standard	Documentation
Providers provide EIS at or in coordination with documented key points of entry.	<ul style="list-style-type: none"> <li>• HCS provider has signed and dated MOU that outlines the responsibilities, obligations of each party.</li> </ul>
HCS supplements and does not supplant existing funds for testing.	<ul style="list-style-type: none"> <li>• HCS provider has policy and procedures on file.</li> </ul>
EIS include referral to appropriate services based on HIV status.	<ul style="list-style-type: none"> <li>• HSC provider documents the number of referrals for health care and supportive services based on individual’s HIV status.</li> </ul>

## Early Intervention Services

EIS include linkage to appropriate services based on HIV status.	<ul style="list-style-type: none"> <li>HSC provider documents the number of linkages to health care and supportive services based on individuals HIV status.</li> </ul>
EIS include health education and literacy training to navigate the HIV system of care.	<ul style="list-style-type: none"> <li>HSC provider documents the training and education sessions designed to help individuals navigate and understand the HIV system of care.</li> </ul>

### Staff Qualifications

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

Standard	Documentation
Trained staff provides EIS services.	<ul style="list-style-type: none"> <li>Personnel files, resumes or employment applications, reflect requisite experience or education.</li> </ul>
Staff providing HIV testing activities will operate in accordance with local, state, and federal guidelines.	<ul style="list-style-type: none"> <li>HSC provider documents that HIV testing activities and methods meet CDC and state requirements.</li> </ul>
HCS provider must structure outreach activities targeting specific at risk populations.	<ul style="list-style-type: none"> <li>HSC provider has policies and procedures addressing how subrecipient will reach the target population.</li> </ul>

### Records Management

**Purpose:** To document evidence of the delivery of all four required service components listed in the table below.

Standard	Documentation
<p>HCS provider <u>must</u> provide or assure seamless linkage of these services:</p> <ol style="list-style-type: none"> <li>Counseling and HIV testing</li> <li>Referral to appropriate services based on HIV status</li> <li>Linkage to care</li> <li>Education and health literacy training for clients to help them navigate the HIV care system</li> </ol>	<p>Provider documents provision of, or seamless linkage of, all four required EIS service components.</p>
HCS provider will report on numbers of HIV tests and positives, as well as where HIV testing occurs.	<ul style="list-style-type: none"> <li>Provider reports the number of HIV tests conducted and number of positives found.</li> <li>Provider reports where HIV testing occurs and number of tests provided.</li> </ul>

## Early Intervention Services

<p>HCS provider tracks referrals for health care and supportive services.</p>	<ul style="list-style-type: none"> <li>• Provider reports referrals for health care and supportive services based on HIV status.</li> <li>• Provider reports referrals from key points of entry to EIS programs.</li> </ul>
<p>HCS provides training and education sessions designed to help individuals understand and navigate the HIV system of care.</p>	<ul style="list-style-type: none"> <li>• Provider documents numbers of training and education sessions that help individuals navigate and understand the HIV care system.</li> <li>• Provider reports number of training and education sessions designed to help HIV negative individuals navigate and understand the HIV system of care.</li> </ul>
<p>HCS providers must be able to provide quantified program reporting activities.</p>	<ul style="list-style-type: none"> <li>• Provider reports on Performance Indicators and Outcome Measures.</li> </ul>

# Emergency Financial Assistance

## Emergency Financial Assistance

### Service Category Definition

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

### *Program Guidance:*

Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

### Client Characteristics

PLWH who need emergency financial assistance in order improve or maintain health outcomes, including viral suppression.

### Unit of Service

Providers must document each Emergency Financial Assistance service. For example, one service unit equals:

- One-time payment of monthly rent
- One-time payment of utility bill
- Voucher card for cell phone minutes/data plan

### Strategies

- Emergency Financial Assistance is meant to be a one-time service to ensure that PLWH be able to maintain healthy outcomes including viral suppression and housing stability.
- RWHAP should continue to be payer of last resort if other resources are available.
- HCS providers should work to develop policies to determine client eligibility for EFA.
- Meaningfully incorporate consumer feedback into program design, implementation, and evaluation.
- Questions regarding allowable covered expenses can be directed to HIV Community Services Supervisor or contract manager.

### Key Activities

- Eligibility
- Referral
- Records management

# Emergency Financial Assistance

## Data

Providers must document and be prepared to share with DOH the design, implementation, populations, and outcomes of Emergency Financial Assistance, including:

- Number of individual clients receiving EFA

Standard	Documentation
<p>HCS records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.</p> <p>Support for Emergency Financial Assistance (EFA) for essential services including utilities, housing, food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either:</p> <ul style="list-style-type: none"> <li>• Short-term payments to agencies</li> <li>• Establishment of voucher programs</li> </ul> <p>Note: Direct cash payments to clients are not permitted.</p>	<p>HIV Community Services Records include:</p> <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Documentation that client meets eligibility criteria</li> <li>• Copy of check or voucher, if appropriate</li> </ul> <p>Using DOH database, HCS provider will document services in progress logs with corresponding service units, and in service plan.</p>

## 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 (ISP)
- 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.

# Food Bank/Home-Delivered Meals

## 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	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 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 has documentation of client FPL.
<p>Eligibility for services will include Washington State residency.</p> <p>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).</p> <p>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).</p>	HCS provider has documentation of Washington State residency specific to funding source.
Eligibility for services will include if client is living with HIV.	HCS provider has documentation of HIV status.
<p>Food Bank/Home-delivered Meal services are limited to the following types of needs:</p> <p><b>FOOD</b></p> <ul style="list-style-type: none"> <li>• Actual food items</li> <li>• Nutritional supplements</li> <li>• Prepared meals</li> <li>• A voucher program to purchase food</li> </ul> <p><b>NON-FOOD Items</b></p> <ul style="list-style-type: none"> <li>• Personal hygiene products</li> <li>• Household cleaning supplies</li> <li>• Water filtration/purification systems in communities where issues of water safety exist</li> </ul>	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 tracks assessments in the client’s individual service plan.

## Food Bank/Home-Delivered Meals

### 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	Documentation
HCS provider will work collaboratively with the client to assess client’s nutritional needs.	Provider has documentation of an assessment that demonstrates client needs food support.
HCS Provider assists clients in developing a long-term plan that includes: <ul style="list-style-type: none"> <li>• Goal</li> <li>• Expected outcomes</li> <li>• Actions taken to achieve goal</li> <li>• Persons responsible for offering such action</li> <li>• Target date for completion of each action</li> </ul> Results of each action	HCS provider documentation that each client has an individualized service plan that contains required elements.
HCS provider reassesses clients need for service on a regular basis.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.
HCS provider will work collaboratively with the client to maximize the client’s access to 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	Documentation
HCS provider will obtain appropriate licensure/certification for Food Bank/Home-delivered meals, where required under State or local regulation.	HCS provider has documentation of any required licensure/certification.
HCS provider shall adhere to all federal, state, and local public health food safety regulations.	HCS provider will maintain file records of local health department food handling/food safety inspections.



## Food Bank/Home-Delivered Meals

### Volunteers

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

Standard	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	<p>Provider has a volunteer orientation curriculum.</p> <p>Evidence of :</p> <ul style="list-style-type: none"> <li>• Volunteer application</li> <li>• Training</li> <li>• Supervision</li> </ul> <p>Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.</p>

### Records Management

**Purpose:** Service providers link clients with access to nutritional needs. Providers must document in DOH database that client received Food Bank/Home-delivered Meal services. Vouchers must be securely stored and securely transferred with limited staff access.

Standard	Documentation
Food Bank/Home-delivered meals records are complete accurate, confidential, and secure.	<p>Food Bank/Home-delivered meals Records include:</p> <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Documentation that client meets eligibility criteria</li> <li>• Copy of check or voucher or tracking of voucher's unique bar code</li> </ul> <p>Using the DOH database, HIV Community Service provider will document services in progress logs with corresponding service units and dollar amount.</p>
HCS provider will ensure security of vouchers.	HCS provider has policy and procedures on file.
HCS provider tracks distribution of vouchers.	HCS provider has policy and procedures on file.
HCS providers must be able to provide quantified program reporting activities.	Provider reports 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 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.
- If a RWHP recipient makes a one-time payment for a client's utility or housing bill, this should be categorized as emergency financial assistance. A housing assessment and individualized housing plan would not be required for a one-time housing payment provided under emergency financial assistance.

### 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.

# Housing Services

- 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	Documentation
Providers provide housing services to HIV positive persons who need services to reduce housing insecurity and improve health outcomes.	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 has documentation of client FPL.
Eligibility for services will include Washington State residency.	HCS provider has documentation of Washington State residency specific of funding source.

## Housing Services

<p>For Housing Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties).</p> <p>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).</p>	
<p>Eligibility for services will include client is HIV positive.</p>	<p>HCS provider has documentation of HIV status.</p>
<p>Housing services are limited to the following types of needs:</p> <p><b>RENT</b></p> <ul style="list-style-type: none"> <li>• Rent</li> <li>• Past-due rent</li> <li>• First month's rent</li> <li>• Rental application or background check fees</li> <li>• Lot rent</li> </ul> <p><b>UTILITIES (on going need)</b></p> <ul style="list-style-type: none"> <li>• Essential utilities (gas, electric, water, propane)</li> <li>• Past-due essential utilities</li> </ul> <p><b>HOTEL or MOTEL or SHELTER</b></p> <ul style="list-style-type: none"> <li>• Hotel or Motel or Shelter voucher</li> </ul> <p><b>OTHER</b></p> <ul style="list-style-type: none"> <li>• Services as approved by WA DOH</li> </ul> <p><b>NOT ALLOWED</b></p> <ul style="list-style-type: none"> <li>• One-time payment for utilities</li> <li>• One-time payment for rent</li> <li>• Mortgage Payments</li> <li>• Refundable deposit</li> </ul>	<p>HCS provider has documentation that funding was limited to the allowable usage categories</p>
<p>Eligibility for housing services must include evidence of tenancy or residency.</p>	<p>Client file includes evidence of tenancy or residency.</p>

### Housing Plan

**Purpose:** Housing assistance is limited to 24 months. To help client's 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.

## Housing Services

Standard	Documentation
<p>Housing services must be limited to short-term support (less than 24 months) of the allowable usage categories.</p>	<ul style="list-style-type: none"> <li>• HCS provider will track usage in DOH database.</li> <li>• Provider has a tracking system</li> </ul>
<p>HCS Provider assists clients in developing a long-term housing placement plan that includes:</p> <ul style="list-style-type: none"> <li>• List of client service needs</li> <li>• Establishment of short and long-term objectives for housing assistance</li> <li>• Establishment of objectives to secure employment or public benefits for financial planning</li> <li>• Establishment of objectives for obtaining or staying in medical care</li> <li>• Establishment of objectives to address other issues identified in the assessment as barriers to stable housing</li> <li>• Objectives and action steps to meet short and long-term goals</li> <li>• Schedule of medical and supportive service appointments that client must keep to continue receiving housing services</li> <li>• Resources to be used to meet client goals</li> <li>• Documentation of client’s participation in long-term housing placement planning process</li> </ul>	<p>HCS provider has long-term housing placement plan in clients Service Plan. Housing plans should be updated monthly to reflect consecutive months assistance.</p>
<p>HCS provider will complete an Assessment/reassessment at time of application or renewal.</p> <p>For Rental Assistance, HCS provider must complete renewals every six months at minimum.</p> <p>For motel, hotel, shelter, or utilities assistance, HCS provider must complete renewals every month at minimum.</p>	<p>Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.</p>

# Housing Services

## Application Completion

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

Standard	Documentation
HCS providers will complete Short Term Housing Assistance Application for each housing assistance request.	Application is complete and present in client file.
HCS providers collect all required supporting documents.	<p>Required supporting documents are present in client file with Housing Assistance Application.</p> <ul style="list-style-type: none"> <li>• For rent, past-due rent, first month’s rent, lot rent, or rental application or background check fees:</li> <li>• Rental agreement or lease</li> <li>• Any additional forms your financial department requires (e.g. W-9)</li> </ul> <p>For past-due utilities:</p> <ul style="list-style-type: none"> <li>• Utility bill</li> <li>• Any additional forms your financial department requires (e.g. W-9)</li> </ul> <p>For hotel/motel vouchers:</p> <ul style="list-style-type: none"> <li>• Statement including costs</li> <li>• Any additional forms your financial department requires (e.g. W-9)</li> </ul>

## 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	Documentation
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.	HCS provider produces and maintains documentation that ensures providers made payments to appropriate vendors.

## Records Management

**Purpose:** Using the DOH database, HSC providers will document housing assistance services in progress logs with corresponding service units.

## Housing Services

Standard	Documentation
<p>Housing Assistance records will reflect compliance with the Housing Assistance Standards outlined above. Records must be complete, accurate, confidential, and secure.</p>	<p>Housing Assistance Records include:</p> <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Documentation that client meets eligibility criteria</li> <li>• Copy of check or voucher</li> </ul> <p>Using the DOH database, HIV Community Service provider will document Housing Assistance services in progress logs with corresponding service units (equal to bed nights for all rent, motel, or hotel subsidies) and the dollar amount.</p>
<p>HCS providers must be able to provide quantified program reporting activities.</p>	<p>Provider is able to report on Performance Indicators and Outcome Measures.</p>

## 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:

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



# Linguistic Services

## 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	Documentation
Linguistic services are provided to HIV positive persons who need translation assistance to obtain core medical or support 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 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 has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is 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	Documentation
HCS providers develop an individualized service plan with each client served.	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.	Provider tracks additional assessments within the Comprehensive Assessment, Service Plan, or Service Plan Reassessment.

# Linguistic Services

## Trained Staff Provide Linguistically Appropriate Services

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

Standard	Documentation
Providers of Linguistic services meet training and qualifications based on available State or 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	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	<ul style="list-style-type: none"> <li>• Provider has orientation curriculum on file.</li> <li>• Evidence of :               <ul style="list-style-type: none"> <li>o Volunteer application</li> <li>o Training</li> <li>o Supervision</li> </ul> </li> <li>• Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.</li> </ul>

## Records Management

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

Standard	Documentation
Linguistic Services records will reflect compliance with the Linguistic Assistance Standards outlined above. Records must be complete, accurate, confidential, and secure.	Linguistic Services Records include: <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Type of provider requesting and receiving service</li> <li>• Type of service provided</li> <li>• Documentation that client meets eligibility criteria</li> </ul>
Records track utilization of assistance.	Using the DOH database, HIV Community Service provider will document linguistic services in progress logs with corresponding service units.
HCS providers must be able to provide quantified program reporting activities.	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

# Medical Transportation

- Records management

## Data

Providers must document and be prepared to share with DOH 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	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 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 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 has documentation of Washington State residency, specific of funding source.
Eligibility for services will include client is HIV positive.	HCS provider has documentation of HIV status.

## Medical Transportation

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, tokens, gas cards)
- Taxi cabs services invoiced to provider at cost.

HCS provider has documentation that funding was limited to the allowable usage categories.

# Medical Transportation

## Medical Transportation Plan

**Purpose:** HCS provider develops an individualized service plan that supports need for Medical Transportation Services. The Medical Transportation Plan may be part of the client's ISP.

Standard	Documentation
HCS provider must assess needs and status of each client receiving medical transportation services.	Using the DOH database, HIV Community Service provider will document medical transportation services in progress logs with corresponding service units and dollar amount.
HCS providers develop an individualized service plan with each client served.	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.	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	Documentation
A system is in place to account for the purchase and distribution of vouchers, tokens, or passes.	HCS provider has documentation of purchase and distribution of vouchers, tokens, or passes.
HCS provider does not provide direct transportation services to clients in need of emergency medical care and there is a policy to address this.	Provider has a policy against providing direct transportation services to clients in need of emergency medical care.

# Medical Transportation

## Volunteers

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

Standard	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	<ul style="list-style-type: none"> <li>• Provider has an orientation curriculum on file.</li> <li>• Evidence of:               <ul style="list-style-type: none"> <li>o Volunteer application</li> <li>o Training</li> <li>o Supervision</li> </ul> </li> <li>• Signed &amp; dated form on file that outlines responsibilities, obligations, &amp; liabilities volunteer.</li> </ul>

## Records Management

**Purpose:** Using the DOH database, HSC providers will document transportation assistance services in progress logs with corresponding service units. 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	Documentation
Medical Transportation Service records will reflect compliance with standards outlined above. Records are complete accurate, confidential, secure.	<p>Medical Transportation Records include:</p> <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Documentation that client meets eligibility criteria</li> <li>• Copy of check or voucher</li> </ul> <p>Using the DOH database, HIV Community Service provider will document services in progress logs with corresponding service units and dollar amount.</p>
HCS provider will develop policy to ensure security of vouchers.	HCS provider has policy and procedures on file.
HCS provider tracks 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.	HCS provider has policy and procedures on file.
HCS providers must be able to provide quantified program reporting activities.	Provider is able to report on Performance Indicators and Outcome Measures.

# Non-Medical Case Management Services

## 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



# Non-Medical Case Management Services

- 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 clients receiving 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	Documentation
Mental health services are limited to psychological and psychiatric treatment and counseling services for PLWH with a diagnosed mental illness.	HCS provider has documentation that funding was limited to the allowable usage categories
Mental health services are for people living with HIV who need help coping with emotional and psychosocial issues that affect health outcomes.	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 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 has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is living with HIV	HCS provider has documentation of HIV status.

## Non-Medical Case Management Services

### Mental Health Plan

**Purpose:** HCS provider develops an individualized service plan that supports need for mental health. The mental health plan may be included in the client’s ISP.

Standard	Documentation
HCS provider must assess needs and status of each client receiving mental health services	HCS provider will track assessments in the DOH database.
HCS providers develop an individualized service plan with each client served.	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.	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	Documentation
Clients will receive mental health services from appropriately licensed and credentialed providers.	HCS provider has a copy of Washington License or Certificate for every mental health provider receiving payment.
PLWH will be able to access services in a timely manner.	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	Documentation
HCS providers who do not directly provide mental health services <u>must</u> systematically provide access to services.	Provider documents the elements of linked referrals in Progress logs and in the 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.	Signed release of information is in client file.

## Non-Medical Case Management Services

HCS providers will identify and assist in resolving any barriers client may have that impede access to mental health services	HCS provider will document all barriers identified in referral process and actions taken to resolve them in Progress logs and in the Service Plan.
HCS provider will ensure clients are accessing referrals and services, and are following through with their referral plan.	HCS provider will document follow-up activities and outcomes in Progress logs, Service Plan, or through other tracking mechanisms.  HCS provider will document client refusal of follow through or referral in the DOH database Progress logs.

### 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	Documentation
HCS provider will effectively utilize and allocate expenditures.	HCS provider has a tracking system in place it updates monthly or when services are provided/paid.  Using the DOH database, HIV Community Service provider will document services in progress logs with corresponding service units.
HCS provider verifies that client cannot access mental health services through other payers, such as Early Intervention Program, Medicaid, or Health Insurance	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.	Provider is able to report on Performance Indicators and Outcome Measures.

### Records Management

**Purpose:** Using the DOH database, HSC providers will document mental health services in progress logs with corresponding service units.. Further discussion of records management criteria, determination, and documentation are in Universal Standards.

Standard	Documentation
Mental health services records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.	<ul style="list-style-type: none"> <li>• Mental health services records include:                             <ul style="list-style-type: none"> <li>o Date client received assistance</li> <li>o Documentation that client meets eligibility criteria</li> <li>o Copy of check or voucher</li> </ul> </li> <li>• Using the DOH database, HIV Community Service provider will document service units in Service Plan.</li> </ul>

## Non-Medical Case Management

### Service Category Definition

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

### Key Activities

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

### Program Guidance

NMCM services objective is to provide coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

### Data

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

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

# Non-Medical Case Management Services

## Standards

Standard	Documentation
<p>HCS records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.</p> <p>Support for Non-Medical Case Management services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services may include:</p> <ul style="list-style-type: none"> <li>• Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible.</li> <li>• All types of case management encounters and communications (face-to-face, telephone contact, other).</li> <li>• Transitional case management for incarcerated persons as they prepare to exit the correctional system.</li> </ul> <p>Note: Does not involve coordination and follow up of medical treatments.</p>	<p>HIV Community Services Records include:</p> <ul style="list-style-type: none"> <li>• Date of encounter</li> <li>• Type of encounter</li> <li>• Duration of encounter</li> <li>• Key activities, including benefits/ entitlement counseling and referral services</li> </ul> <p>Using DOH database, HCS provider will document services in progress logs with corresponding service units, and in the service plan.</p>

## Outreach Services

### Service Category Definition

Outreach activities have as their principal purpose as 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 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 categories identified through the 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 Outreach 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 qualify 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

# Outreach Services

treatment services, or do not adhere 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 Data to Care Coordinator and Disease Intervention Specialists, local clinics, 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
- Peer Navigation

## 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.

## Outreach Services

Standard	Documentation
Eligibility for services will include FPL used by Early Intervention Program.	HCS provider has documentation of client FPL.
Initial Determination of Eligibility for Case Management does not include income.	HCS provider collects and documents within the DOH database information on Client FPL within thirty (30) days of initiating intake.
<p>Eligibility for services will include Washington State residency.</p> <p>For Outreach Services funded by DOH, eligibility for services will include residency in WA State outside the TGA (King, Snohomish, and Island Counties).</p> <p>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).</p>	HCS provider has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is living with HIV.	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	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.	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.	HCS provider documents research findings.
Provider plans and delivers outreach programs in coordination with state and local HIV-prevention outreach programs.	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	Documentation
Outreach must include information and education about HIV and the HIV service delivery system.	Written materials and outreach protocols demonstrate the required components.



## Outreach Services

Outreach must include information and education about remaining in HIV care and accessing intensive services as needed.	Written materials and outreach protocols demonstrate the required components.
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### 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	Documentation
Outreach providers ensure that they make every effort to bring or retain at-risk clients in care.	Engagement and retention policies and procedures are on file.
Providers of maintenance outreach will complete a transition and case closure summary.	Transition or case closure summaries include: <ul style="list-style-type: none"> <li>• Date of engagement or retention activities</li> <li>• Efforts made to engage or retain</li> <li>• Reasons for transition or case closure and criteria for re-entry into services.</li> </ul>

### 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	Documentation
Outreach Services records will reflect compliance with standards. Records are complete accurate, confidential, and secure.	Outreach services records include: <ul style="list-style-type: none"> <li>• Date client received assistance</li> </ul> Using the DOH database, HCS provider documents services in progress logs with corresponding service units, and in the service plan when client successfully engages.

# Outreach Services

## Peer Navigation

**Purpose:** Peer Navigation services provide intentional, trauma-informed, strengths-based peer support to people living with HIV (PLWH). Peer Navigation is rooted in the field of Peer Support. This means shared lived/living experience becomes a tool to model and support Client wellness. Peer Navigators can work with Peers Clients at the individual, group, and community levels. They work to provide person-centered services to clients; making sure clients feel supported and engaged and are linked to the right services. These services may be case management, medical healthcare, medication engagement, housing, community partners, mental/behavioral healthcare, substance use/harm reduction supports, and other systems. Peer Navigation explores and develops a fair and affirming approach to supporting a Peer Client's agency, self-efficacy, and empowerment in guiding the work.

## Skills and Knowledge

Preferably Peer Navigators are:

- living with HIV (or have firsthand knowledge of the HIV experience)
- healthcare and medication engaged role models, and
- living as part of the community and populations they work with.

Peer Navigation recognizes that PLWH have skills and abilities unique to the experience of living with HIV. Often Peer Navigators also see themselves as living in mental/behavioral health, substance abuse, and trauma recovery. This combination of experiences shows how a Peer Navigator is a person who is a valuable resource, having comprehensive knowledge and expertise in the field of HIV.

## Scope of Work, Goals and Objectives

Peer Navigation reflects a philosophy that affirms a Peer Client's right to agency, confidentiality, respect, and self-determination. Peer Navigators seek out areas of commonality to build a connection with their Client. Also, when appropriate, Peer Navigators mindfully use their personal living/lived experience to support the relationship with the Client. This work calls for the Peer Navigator to be vulnerable, while keeping professional and ethical boundaries. Peers Clients are collaboratively engaged in goal setting, exploring supports needed to achieve their goals, and actively take part in accountability and action. Through this experience the Peer Client works towards self-regulation, skill confidence, and graduation from Peer Navigation services.

Peer Navigation focuses on providing support to Clients facing challenges such as:

- being newly diagnosed
- being non-virally suppressed
- being out of care or at risk of falling out of care
- dealing with:
  - mental/behavioral health
  - substance use or recovery
  - HIV related stigma
  - social isolation

## Outreach Services

- being justice-involved
- experiencing housing instability
- experiencing a life disruption or event that is impacting their self-regulation

This special focus stresses connection to healthcare and medication engagement to strive towards viral load suppression or best level of health (recognizing the various social determinants of health).

The objectives of Peer Navigation are to:

- Promote knowledge and skill building to boost Client ability to navigate living with HIV and the systems they are involved with.
- Provide linkage to resources and services aimed to support the Client's stability.
- Assist Client to gain/maintain access and engagement to relevant care and treatment.
- Model and promote viral suppression for the purpose of preventing the transmission of HIV and maximizing the potential health and wellbeing of the Client.
- Collaborate and support:
  - Case Managers
    - in sharing information to assess Client needs and build upon their strengths and capabilities
    - support Client's Individual Service Plan to build on those strengths and overcome their challenges
  - Housing Case Managers to support Client housing stability
  - Healthcare and Mental/Behavioral Healthcare Providers
  - Substance Use Recovery Programs
  - Employment programs
  - The Department of Corrections HIV Service Providers, Probation, or Parole Officers
  - The Department of Social and Health Services and/or the Social Security Administration

### Timeframe for Peer Navigation

Peer Navigation is a structured, time-framed intervention. The needs of the Peer Client guide this type of intervention. It may be brief if the Peer Client only needs situational support. Or it may need more time if a Peer Client is experiencing disruptions in multiple areas of their lives and functioning. If Peer Navigation services reach a 6-month mark, the Peer Client and Case Manager should meet to explore a Navigation Plan. This collaborative meeting can identify goals, explore plans and supports needed to meet goals, and delineate a considered time-frame for Peer Navigation support in achieving Peer Client goals. If the Peer Client continues to need additional peer support by the end of the time-frame, the Peer Client and Case Manager need to meet to determine an action plan moving forward. Peer Navigation supports the Peer Client in connecting to their strengths, abilities, resiliency, self-advocacy, and autonomy. There may be a need to Re-evaluate the Peer Client's need for support if the Peer Client keeps needing Peer Navigation Services after 18 months. By this time, other supportive services like mental/behavioral health, substance recovery, or other community resources should be in place. A firm level of rapport between the Peer Client and their healthcare providers is expected as well. There may be situations where Peer Navigation services are still needed if these points haven't been

## Outreach Services

met and the case calls for continued support, but if services are to continue past 18 months, the need must be specific, boundaries of the relationship clarified, and a plan to conclude established.

It is important to note that the closing of a Peer Navigation referral is a decision made collaboratively with the Peer Client, Peer Navigator, and Case Manager.

### Professional Practices for Peer Navigators

Peer Navigators are professionals paid to support their Peer Clients during defined work hours. As Peer Navigators are often part of the same communities as their Peer Clients, it is imperative to maintain clear, healthy, and professional boundaries with them. To keep these boundaries, Peer Navigators:

- will not use personal social media, mobile phones, or email when engaging with Peer Clients
- will not engage with Peer Clients in person, phone, or text outside of work hours
- will not use personal money or financial resources to support any action of a Peer Client
- will not use private vehicles or transportation apps in service of Peer Clients outside of work hours

Peer Navigator may need to provide services outside of work hours during unique times or events. In cases like these, the Peer Navigator will require documentation, clearance, and approval from Management.

Liability and safety for both Peer Navigators and Peer Clients necessitate sole support and attention. Peer Navigators may be living in the same community as Clients. Therefore, social situations, either in-person or online (Social media, Dating, or Hook-up Apps), may present themselves. These can be tricky or challenging and can sometimes place the Peer Navigator or Peer Client in a situation that can cross professional and personal boundaries and possibly put either or both in danger. When situations like this happen, the Peer Navigator will report the incident to their managing Steward to assess and create steps to address the event. Transparency is paramount, as is the safeguarding of all involved.

### Documentation Practices for Peer Navigators

Documentation is evidence that a Peer Client has received Outreach Services. Peer Navigation records will reflect compliance with the Case Management Standards of Care. Documents must be complete, accurate, confidential, and secure. Peer Navigators will use the DDAP (Domain, Data, Assessment, and Plan) model in Provide unless otherwise noted. **Documentation is equally important to service delivery.** It provides a narrative that can support the work of a Client's care team, but it also supplies DATA to support the efficacy of Peer Navigation services.

### WA DOH Peer Navigation Support

The WA DOH Peer Navigation Consultant (PNC) provides technical assistance, support, and guidance. Monthly, individual meetings with the PNC provide Peer Navigators the opportunity for case conference/Co-Reflection, share challenges, successes, and access support in the work. The PNC coordinates Monthly Peer Navigation Group programming to build community amongst Peer Navigators, provide space for group case conferencing/Co-Reflection, and provide Workshops that support the work. The PNC will also offer monthly support to Peer Navigation Stewards in individual Co-Reflection meetings and access to monthly Peer Navigation Workshops.

# Outreach Services

## Unit of Service

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

## Strategies

- Provide peer navigation services for PLWH in compliance with WA State HIV Client Service Standards, understanding that the relationship of peer/client does not always mirror that of the case manager/client relationship.
- Prioritize medical engagement/retention, viral suppression, and stable housing as recognized indicators of positive health outcomes and quality of life.

## Peer Navigation

**Purpose:** Providers of Peer Navigation services.

Standard	Documentation
Peer navigation records will reflect compliance with the Case Management Standards of Care.  Records must be complete, accurate, confidential, and secure.	Peer Navigation records include: <ul style="list-style-type: none"><li>• Date of client visit or contact</li><li>• Reason for visit or contact</li><li>• Activities performed</li><li>• Outcome</li><li>• Follow-up Plan</li></ul> Documentation that client meets eligibility criteria  Using DOH Data System, HCS provider documents Peer Navigation services in progress logs with corresponding service units.
HCS providers must be able to provide quantified program reporting activities.	Provider is able to report on Performance Indicators and Outcome Measures.

## 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 not 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 healthy 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

# Psychosocial 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	Documentation
Psychosocial support is for persons living with HIV who need assistance to empower themselves to develop healthier lives.	HCS provider has documentation that client needs psychosocial support services.
Initial Determination of Eligibility for Case Management does not include Income.	HCS provider collects and documents within the DOH database 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 has documentation of Washington State residency specific of funding source.
Eligibility for services will include client is living with HIV	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	Documentation
Psychosocial Support providers will offer client-driven, medically accurate group(s) to help improve the quality of life for participants.	Psychosocial support providers will maintain group records that include: <ul style="list-style-type: none"> <li>• Dated sign-in sheets</li> <li>• Number of participants attended</li> <li>• Name and title of group facilitator</li> <li>• Location of group</li> <li>• Copies of handouts</li> <li>• Summary of the topics discussed</li> <li>• Activities conducted</li> <li>• Goals and objectives achieved during group session</li> </ul>

# Psychosocial Support Services

## Counseling

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

Standard	Documentation
Psychosocial Support providers will offer client-driven, medically accurate counseling to help improve the quality of life for participants.	Psychosocial support providers will maintain client records that include: <ul style="list-style-type: none"> <li>• Date</li> <li>• General topics discussed</li> <li>• Activities conducted</li> <li>• Goals and objectives achieved during counseling sessions</li> </ul>

## 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	Documentation
The provider will develop referral resources for services to meet the needs of their clients.	Referral lists will be available for inspection.
Providers will demonstrate active collaboration to provide referrals to the full spectrum of services.	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 documents all referrals within Progress logs, Services, or Service Plans.

## Records Management

**Purpose:** Using the DOH database, HSC providers will document psychosocial support services in progress logs with corresponding service units. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Documentation
Psychosocial support services records will reflect compliance with standards outlined above. Records are complete accurate, confidential, secure.	Psychosocial support services records include: <ul style="list-style-type: none"> <li>• Date client received assistance</li> </ul> Using the DOH database, HCS provider will document services in progress logs with corresponding service units, and in the 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:
  - o Pretreatment or recovery readiness programs
  - o Harm reduction
  - o Behavioral health counseling associated with substance use disorder
  - o Outpatient drug-free treatment and counseling
  - o Medication assisted therapy
  - o Neuro-psychiatric pharmaceuticals
  - o 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:

- 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.

# Substance Abuse Outpatient Services

- 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 DOH 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	Documentation
Substance abuse outpatient services are for PLWH who need help coping with drug and alcohol issues that affect health outcomes.	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 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 WA State outside the TGA (King, Snohomish, and Island Counties).  For Substance Abuse Services funded by PHSKC Ryan White, eligibility for services will include	HCS provider has documentation of Washington State residency specific of funding source.

## Substance Abuse Outpatient Services

residency in WA State within the TGA (King, Snohomish, and Island Counties).	
Eligibility for services will include client is HIV positive.	HCS provider has documentation of HIV status.
Providers pay for substance abuse outpatient services provided 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. This may be part of the client’s ISP.

Standard	Documentation
<p>Substance abuse outpatient services treatment plan includes only allowable activities and includes:</p> <ul style="list-style-type: none"> <li>• The quantity, frequency, and modality of treatment provided</li> <li>• The date treatment begins and ends</li> <li>• Regular monitoring and assessment of client progress</li> <li>• The signature of the individual providing the service.</li> </ul>	<ul style="list-style-type: none"> <li>• Program files and client records include a treatment plan that includes the quantity, frequency, and modality of treatment provided.</li> <li>• Client record includes a treatment plan that includes the date treatment begins and ends.</li> <li>• Program files and client records include a treatment plan that includes regular monitoring and assessment of client progress.</li> <li>• Program files and client records include a treatment plan that includes the signature of the individual providing the service.</li> </ul>

### 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	Documentation
Clients will receive substance abuse outpatient services from a physician or qualified/licensed personnel.	HCS provider has a copy of Washington License or Certificate for every substance abuse outpatient provider receiving payment.
PLWH will be able to access services in a timely manner.	HCS provider’s substance abuse outpatient services policies and procedures indicate how needs of clients are managed.

# Substance Abuse Outpatient Services

## 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	Documentation
HCS providers who do not directly provide substance abuse outpatient services must systematically provide access to services.	Provider documents linked referrals in progress logs 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.	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 document all barriers identified in referral process and actions taken to resolve them in progress logs and in the treatment plan.
HCS provider will ensure clients are accessing referrals and services, and are following through with their treatment plan.	HCS provider will document follow-up activities and outcomes in progress logs, service plan, or through other tracking mechanisms.

## 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	Documentation
HCS provider will effectively utilize and allocate expenditures.	Provider has an expenditure tracking system.  Using the DOH database, HCS provider will document services in progress logs with corresponding service units.
HCS provider verifies that client cannot access substance abuse outpatient services through other payers, such as: <ul style="list-style-type: none"> <li>• Early Intervention Program</li> <li>• Medicaid</li> <li>• Health Insurance</li> </ul>	HCS provider has policy and procedures on file that stipulate HCS funds are payer of last resort.

# Substance Abuse Outpatient Services

HCS providers must be able to provide quantified program reporting activities.	Provider is able to report on Performance Indicators and Outcome Measures.
--	--

## Records Management

**Purpose:** Using the DOH database, HSC providers will document substance use outpatient services in progress logs with corresponding service units. Further discussion of Records Management criteria, determination, and documentation are in Universal Standards.

Standard	Documentation
Substance abuse outpatient services records will reflect compliance with standards. Records are complete accurate, confidential, and secure.	<p>Substance abuse outpatient Services Records include:</p> <ul style="list-style-type: none"> <li>• Date client received assistance</li> <li>• Documentation that client meets eligibility criteria</li> <li>• Copy of check or voucher</li> </ul> <p>Using the DOH database, HCS provider will document services in progress logs with corresponding service units, and in service plan.</p>

## 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:

<https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf>.

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

According to HIV/AIDS Bureau Policy 15-02, *Quality assurance refers to a broad spectrum of activities aimed at ensuring compliance with minimum quality standards. Quality assurance activities include the retrospective process of measuring compliance with standards (e.g., HHS guidelines, professional guidelines, service standards, contract deliverables)*. DOH 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

# Program Monitoring

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. Chart reviews for Title XIX clients are mandated by DOH's contract with the HCA.

## 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.

# Program Monitoring

## 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	Documentation
HCS records will reflect compliance with standards outlined above. Records are complete, accurate, confidential, and secure.	HIV Community Services Records include: <ul style="list-style-type: none"><li>• Date client received assistance</li><li>• Documentation that client meets eligibility criteria</li><li>• Copy of check or voucher, if appropriate</li></ul> Using DOH database, HCS provider will document services in progress logs with corresponding service units, and in the 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 by providing high quality services. The quality management program focuses on health outcomes and program 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 Improvement

## Quality Management Program Components<sup>1</sup>

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, 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 DOH statewide networked data system necessary to produce DOH selected Performance Measures.
- Measure patient/client experience and/or customer feedback annually.
- Submit a 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 improvement 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.

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<sup>1</sup> US Department of Health and Human Services. Updated 11/30/2018. 201. Clinical Quality Management Policy Clarification /Notice #15-02. Assessed at: <https://hab.hrsa.gov/sites/default/files/hab/Global/CQM-PCN-15-02.pdf> . And <https://hab.hrsa.gov/sites/default/files/hab/Global/clinicalqualitymanagementfaq.pdf>

# Quality Improvement

## Performance Measures

The performance measures that DOH uses to determine progress and to identify areas for improvement are at a minimum for each service category provided. Detailed descriptions of performance measure are available in the quarterly report template and from the DOH Quality Improvement Coordinator

- Engagement in Care Measure: Annual Medical Visits
- Health Outcome Measure: HIV viral load suppression Special Population Health Outcome Measures: HIV viral load suppression for:
  - o Latinx
  - o Black
  - o Unstably housed
- Additional performance measures may be tracked based on identification of disparate impact or other identified disparities as defined by the HIV Planning Steering Group and program data. Such potential focus areas are youth, over 50, transgender, women, and justice involved.

## 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

[www.nationalqualitycenter.org/resources/patient-satisfaction-survey-for-hiv-ambulatory-care-pdf/](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.

Due dates are:

Calendar Quarter	Due Date
January 1 – March 31	April 30
April 1 – June 30	July 30
July 1 – September 30	October 30
October 1 – December 31	January 30

## 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 offer input on the selection of measures and quality improvement projects. DOH may ask HCS providers to participate in additional quality management activities.

# Quality Improvement

## Standards

### Quality Improvement

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

Standard	Documentation
<p>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.</p>	<p>HCS provider documents Quality Committee meetings, including:</p> <ul style="list-style-type: none"> <li>• Date of meeting</li> <li>• Minutes from each meeting</li> <li>• Number of people on the committee</li> <li>• Meeting attendance</li> <li>• Committee recommendations</li> </ul>
<p>HCS provider will develop and periodically update a written provider Quality Plan that is consistent with the Washington State Quality Plan.</p> <p>Quality Improvement Plans are updated at least annually.</p>	<p>HCS provider has a Quality Improvement Plan on file.</p> <p>HCS provider documents all updates to the Quality Improvement Plan upon achievement of goals, and when other issues or goals are identifies, or at least annually.</p>
<p>Providers will undertake short-term Plan Do Study Act (PDSA) activities specifically aimed at evaluating and improving HIV program services.</p>	<p>Provider has evidence of PDSA.</p>
<p>Providers use client satisfaction surveys and other efforts to gauge adequacy of services in meeting client needs.</p>	<p>Provider submits a copy of the findings of the survey and other efforts to DOH.</p>

## COVID-19

### Ryan White CARES Act

Preventing, preparing for, and responding to COVID-19 for Ryan White HIV/AIDS Program (RWHAP) clients, including expenses related to extended operating hours, increased staffing hours (overtime), additional equipment, workforce training and capacity development, and services to support social distancing, such as home delivered meals and transportation. All activities and purchases supported with RWHAP COVID-19 awards **must** be used for services, activities, and supplies needed to prevent or minimize the impact of COVID-19 on RWHAP clients. DOH RW Part B program will submit plans to HRSA that address how CARES Act funds in their state will be used to address one or more of the following pillars:



PREVENT



PREPARE FOR



RESPOND TO

COVID-19

### Eligible Ryan White Service Categories

All activities must still conform to eligible Ryan White service categories:

- Medical Case Management
- Non-Medical Case Management
- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Health education/Risk Reduction
- Housing
- Linguistic Services
- Medical Transportation
- Outreach Services
- Psychosocial Support Services

### Client Characteristics

PLWHA residing in Washington State who have been affected by COVID-19 and could benefit from support, advocacy, resources or benefit from referral and linkage, housing, emergency financial assistance, 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.

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

- Number of individual clients provided related services
- Monthly COVID-19 Data Report (CDR) must be submitted per HRSA requirements

## Exception to Policy

Due to the social distancing requirements put in place by Governor Inslee, the expectation is that HCS providers work within their communities to provide a continuity of services using the following guidelines:

- Services may be provided using tele-health or other remote options
- Services may be provided by appointment only
- HCS providers may allow clients the use of temporary electronic signatures on any documents requiring client signature
- HCS providers may allow for temporary self-attestation to verify residence, income, and HIV status (to be verified in a timely manner by case manager)

As counties begin to follow the phased guidelines outlined in “Safe Start” HCS providers should work with their clients to obtain updated documents and signatures as needed.

Further guidance can be found here: <https://coronavirus.wa.gov/what-you-need-know/safe-start>

## Appendix A

### Trauma Informed Care Self-Assessment Tool

#### Purpose

The Agency Self-Assessment for Trauma-Informed Care is intended to be a tool that will help you assess your organization's readiness to implement a trauma-informed approach. Honest and candid staff responses can benefit your agency by helping to identify opportunities for program and environmental change, assist in professional development planning, and can be used to inform organizational policy change.

#### How to Complete the Agency Self-Assessment

The Self-Assessment is organized into five main "domains" or areas of programming to be examined:

- Supporting Staff Development
- Creating a Safe and Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

Agency staff completing the Self-Assessment are asked to read through each item and use the scale ranging from "strongly disagree" to "strongly agree" to evaluate the extent to which they agree that their agency incorporates each practice into daily programming. Staff members are asked to answer based on their experience in the program over the past twelve months.

Responses to the Self-Assessment items should remain anonymous and staff should be encouraged to answer with their initial impression of the question as honestly and accurately as possible. Remember, staff members are not evaluating their individual performance, but the practice of the agency as a whole. Staff should complete the Self-Assessment when they have ample time to consider their responses; this may be completed in one sitting or in sections if time does not allow.

Agencies may distribute the tool on paper or electronically. Using an electronic method may assist with data collection and analysis.

#### How to Compile and Examine Self-Assessment Results

Have a designated point person to collect completed assessments and compile results.

To identify potential areas for change, look for statements where staff responses are mostly "strongly disagree" and "disagree", these are practices that could be strengthened. In addition, pay attention to those responding with "do not know" as this could indicate that the practice is lacking, or perhaps there is a need for additional information or clarification. Finally, it is helpful to examine items where the range of responses is extremely varied. The lack of consistency might be due to a lack of understanding about an item itself, a difference of perspective based on a person's role in the agency, or a misunderstanding on the part of some staff members about what is actually done on a daily basis.

## Appendix A

This instrument is adapted from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment and “Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol” article by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

### Trauma-Informed Organizational Self-Assessment

Please complete the assessment, reading each item and rating from strongly disagree to strongly agree based on your experience in the organization over the last year. Use your initial impression, and remember, you are evaluating the agency, not your individual performance.

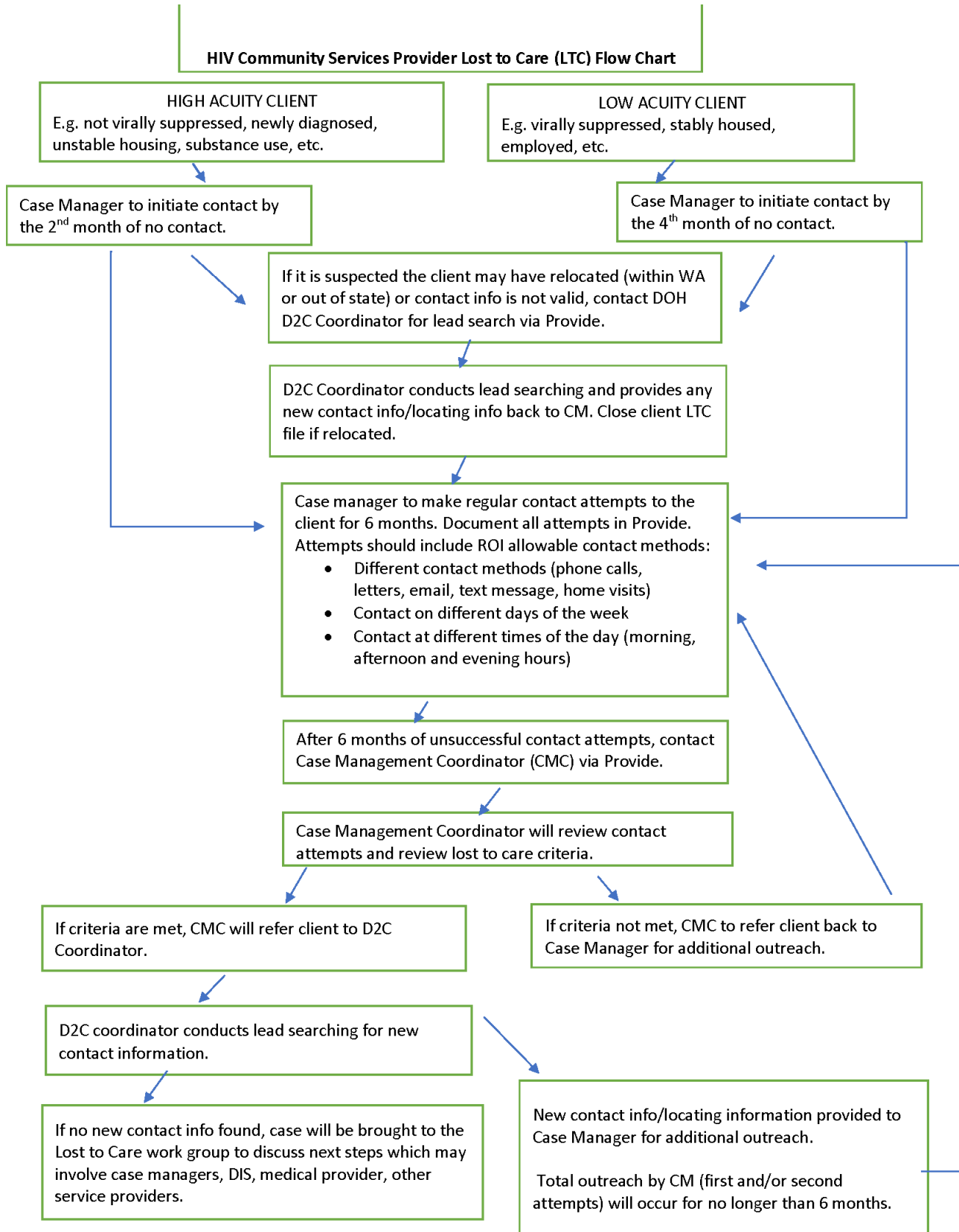
### Supporting Staff Development

Staff at all levels of the program receive training and education on the following topics

<b>Staff at all levels receive training/education on the following</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>	<b>Do Not Know</b>	<b>Not Applicable</b>
What Traumatic Stress is						
How traumatic stress affects the brain/body						
The relationship between mental health and trauma						
The relationship between substance use and trauma						
The relationship between health outcomes and trauma						
How trauma affects a person’s development						



# Appendix B



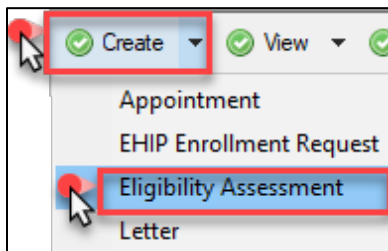
## Appendix C

### Provide® Enterprise System PLWH Eligibility Assessment Manual

Eligibility Assessments are completed to determine eligibility prior to funding and providing services.

A client's eligibility must be **updated every six months**. Only Provide Users with specific security roles are able to “**Submit**” and/or “**Complete**” Eligibility Assessments.

To create an **Eligibility Assessment**, navigate to the **Client Profile** > click on green **Create** button > **select Eligibility Assessment**



**The Eligibility Assessment is composed of 12 tabs:**



- Main
- Demographics
- Address
- Household
- Income
- Benefits
- Insurance
- Authorized Rep
- Medical
- Care Team
- Services
- Progress Logs



When entering data into tabs and forms – **only fields with red asterisks (\*) are required** to submit or complete.

---

## Main Tab

# Appendix C

The Main Tab consists of two sections:

1. **Top section** where key client information (name, birth date, and SSN, etc.) is located.

<b>Main</b>	Demographics	Address	Household	Income	Benefits	Insurance	Authorized Rep	Medical	Care Team	Services	Progress Logs
Assessment ID	41780										
Source	ADAP										
Assessment Type	New Assessment										
Urgent Processing Desired Flag?	No										
Checked Out?	Yes										
Checked Out By	Kelse Kwaiser										
Checked Out Date	08/27/2020										
File Status	In Progress										
Date Received	* 08/27/2020										
Date Due	10/26/2020										
Comments											
- Applicant Identification											
Legal First Name	* [REDACTED]										
Legal Middle Initial											
Legal Last Name	* [REDACTED]										
Name Suffix											
Date of Birth	* [REDACTED]										
Current Age											
Social Security #	- - -										
Current Gender Identity	* Male										
Sex Assigned at Birth	* Male										

2. **Bottom section** where “Proof of Identity” scans, Agreement Release of Information/Assignment of Benefits scans, and past/current Eligibility Assessment Application documents are located.

<b>Proof of Identity</b>
Proof of Identity Document(s)
Date ▾ Type / Delete Flag /
<b>Agreement Release of Information Assignment of Benefits</b>
Agreement Release of Information Assignment of Benefits Document(s)
Date ▾ Type / Delete Flag /
<b>Eligibility Assessment Application Documents</b>
Eligibility Assessment - Application
Date ▾ Delete Flag ▾



Proof of identity is **not required** but is helpful to capture legal name.

## Demographics Tab

# Appendix C

The Demographics Tab is where vital client demographic information on a client is located. Fill in the fields as appropriate, depending on how fields are answered, additional fields may populate.

Demographics

Race - Check all that apply

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White

Native Hawaiian Pacific Islander

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander

Ethnicity

Ethnicity - Hispanic

- Hispanic
- Mexican
- Puerto Rican
- Cuban
- Other

Veteran?

Primary Language

Preferred Written Communications Language

Marital Status

- Single

## Address Tab

The Address Tab is where the address, phone number(s), and proof of residency are documented.

Address

Residence

Housing Type

- \* Home/Apartment you Own/Rent

Street Address

- \* 123 Fake St

Apt / Lot / Floor

State

- \* WA

City

- \* Seattle

County

- \* King

Zip Code

- \* 98108-\_\_

Primary Phone

Secondary Phone

Okay to Leave Voice Mail?

Mailing Address

Do you consent to receiving mail from the program?

- \* Yes

Care Of Line

Street Address

- \* 456 Fake St.

Apt / Lot / Floor

City

- \* Seattle

County

State

- \* WA

Zip

- \* 98108-\_\_

E-Messaging

Okay to Send Email?

- \* No

Okay to Send Text Messages?

- \* No

Proof of Residency

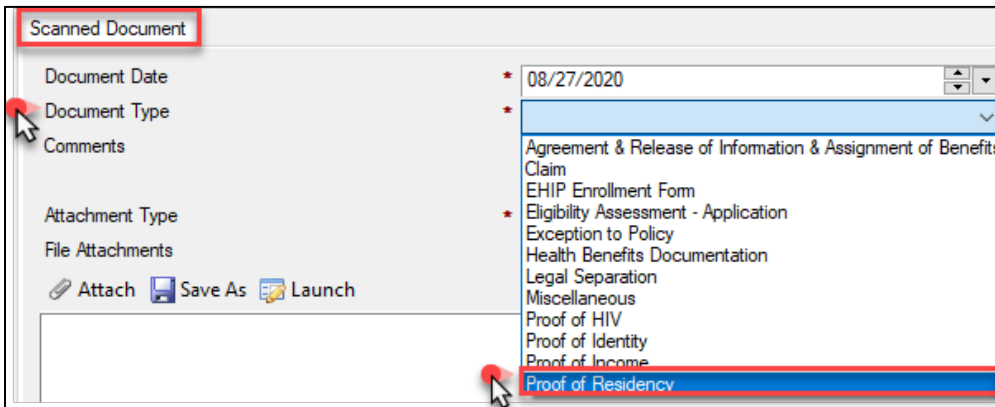
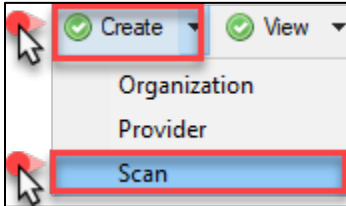
Proof of Residency Document(s)

Date	Type /	Delete Flag /
2020/08/27	Proof of Residency - 123 Fake St, Seattle WA 98108-	N

# Appendix C

**Proof of Residency** documents will be visible and accessible in the bottom section of this tab.

If the documents are missing and need to be added, a user can click on the green **Create** button > **Scan** > Add **Proof of Residency** as image (scan) or attachment (file).

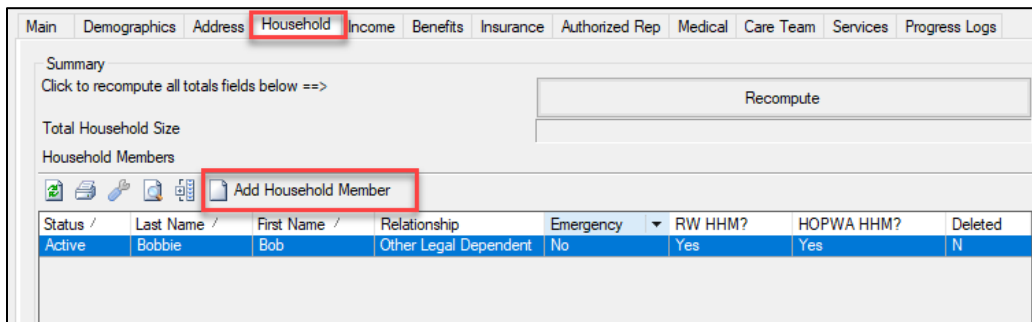


## Household Tab

The **Household** Tab shows the client's legal household members and the household size.

A legal **Household Member** includes:

- Spouse
- RDP
- Child
- Other person client is able to claim on their taxes



Household Member Records can be added by clicking the **Add Household Member Record** form

# Appendix C

Once added, click the big grey **Recompute** button to recalculate the household size based on the new information.

## Income Tab

The Income Tab will be where a user documents the client's income and adjustments.

A user will input the total monthly household income of the applicant and all legal household members in the respective fields.

**Note:** The wages field is the only **required field (\*)** in the income calculations. If there are no wages, you would enter **zero** into this field and move onto entering the income in the other field (s).

Main	Demographics	Address	Household	Income	Benefits	Insurance	Authorized Rep	Medical	Care T
<b>Alert</b> Input the total monthly income of applicant and all legal household members in the respective fields. Any Income type listed in all caps is not calculated for MAGI, but is a required field of entry. Every field in this section needs to have a value. If you don't have the type of income being asked for then you will need to enter a zero (0) in the field.									
Current Monthly Household Income									
Wage Income Calculator					Wage Income Calculator				
Wages, salaries, tips, etc.					\$1,000.00				
Taxable interest									
Tax-exempt Interest									
Ordinary Dividends									
Exempt Interest Dividends									
Taxable refunds of state/local income taxes									
Alimony or Other Spousal Support Received									
Business or Self Employed income/loss (Schedule C or C-EZ)									

Capital gain/loss (Schedule D)	
Other gains/losses	
IRA distributions - taxable amount	
Pensions and Annuities	
Rental real estate, trusts (Schedule E)	
Farm income/loss (Schedule F)	
Unemployment Income	
Retirement Income from Social Security	
Social Security Disability (SSDI)	
SUPPLEMENTAL SOCIAL SECURITY INCOME (SSI)	
Other Client Income (Jury Duty Pay, Gambling Winnings)	
CHILD SUPPORT, WORKMAN'S COMPENSATION, OR MONETARY GIFT	

## Appendix C

<b>Current Monthly Household Income Adjustments</b>	
Educator expenses	<input type="text"/>
Business expenses (Form 2106 or 2106-EZ)	<input type="text"/>
Health Saving Account (Form 8889)	<input type="text"/>
Moving Expenses (Form 3903)	<input type="text"/>
Deductible part of Self-Employment Tax (Schedule SE)	<input type="text"/>
Self-employed SEP, SIMPLE plans	<input type="text"/>
Self-employed Health Insurance Deduction	<input type="text"/>
Penalty on early withdrawal of savings	<input type="text"/>
Alimony paid	<input type="text"/>
IRA deduction	<input type="text"/>
Student loan interest deduction	<input type="text"/>
Tuition and fees (Form 8917)	<input type="text"/>
DOMESTIC PRODUCTION ACTIVITIES (Form 8903)	<input type="text"/>
<b>Totals</b>	
Click to recompute all totals fields below ==>	
	<input type="button" value="Recompute"/>
Household Monthly Gross Income	* \$1,000.00
Household Monthly Gross Income Adjustments	* <input type="text"/>
Household Monthly MAGI	* \$1,000.00
Household MAGI Poverty Level %	* 73
<b>Tax Return</b>	
Did you file a tax return for the most recent prior year?	<input type="text" value=""/>
<b>Income Documentation Requirements</b>	
Attach a copy of current income documents. Examples of current income documents include copies of your most recent last two months of pay stubs, current Social Security award letter, unemployment award letter.	
<b>Income Documentation</b>	
Proof of Income Document(s)	
Date ▾	Type /
Delete Flag /	
2020/08/11	Proof of Income - Household MAGI = 0% FPL
N	

**NOTE:** Any **income** or **adjustment** type listed in all caps will not be included in the MAGI calculation.

**Wages, salaries, tips, etc.** - include the total monthly income that the applicant and any legal household members receive from wages, salaries and tip income.

- If a Case Manager needs assistance entering wages the Wage Calculator is a tool that assists in this calculation.

# Appendix C

After updating the household member (s), and income information, click on the big grey **Recompute** button and the income totals will be recomputed. Select either “Yes” or “No” if the client filed a tax return for the most recent prior year.

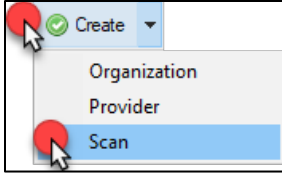
Totals	
Click to recompute all totals fields below ==>	
Household Monthly Gross Income	* \$1,000.00
Household Monthly Gross Income Adjustments	*
Household Monthly MAGI	* \$1,000.00
Household MAGI Poverty Level %	* 73


**Proof of Income documentation** will appear on the documentation tab. A new Proof of Income document is required for every Eligibility Assessment (unless it is up-to-date with SS income or the income document was added within the past 2 months).

- To add an income document click **Create > Scan**> select document type as **Proof of Income > Scan** image or **attach** file.



# Appendix C



**No Income:** - By enter zero into the wages field and if there are no other income sources, click the **Recompute** button and the “No Income Declaration” field will appear. The  hover question mark contains the no income statement info.

A screenshot of the 'Totals' section in a software application. The section is titled 'Totals' and includes the instruction 'Click to recompute all totals fields below ==>'. Below this, there are several fields with red asterisks indicating they are required: 'Household Monthly Gross Income' (\$0.00), 'Household Monthly Gross Income Adjustments' (\$0.00), 'Household Monthly MAGI' (\$0.00), and 'Household MAGI Poverty Level %' (0). A red arrow points to a blue question mark icon next to the 'No Income Declaration?' field, which is currently set to 'Yes'. A 'Recompute' button is located to the right of the fields.

## Benefits Tab

The **Benefits Tab** is where a user can document the client’s Medicare and Medicaid information.

A screenshot of the 'Benefits' tab in a software application. The tab is highlighted in red. The interface shows a navigation bar with tabs: 'Main', 'Demographics', 'Address', 'Household', 'Income', 'Benefits', 'Insurance', 'Authorized Rep', 'Medical', 'Care Team', 'Services', and 'Progress Logs'. Below the navigation bar, there is an 'Alert' section with a warning message: 'It is critical that applicant report enrollment in health benefits programs. Failure to do so may lead to Pemanent Removal from the Medication and/or Premium Assistance Programs.' The main form area contains fields for 'Medicare Status' (with a red asterisk), 'Medicaid Status?', 'Medicaid ID Number', 'Provider One ID', and 'Comments'.

When a user inputs “**Active**” into the **Medicare Status** field, additional required fields (\*) will populate.

## Appendix C

Main Demographics Address Household Income **Benefits** Insurance Authorized Rep Medical Care Tr

Alert  
It is critical that applicant report enrollment in health benefits programs. Failure to do so may lead to Permanent Removal from the Medication and/or Premium Assistance Programs.

Medicare  
Status \* No Benefits

Medicaid  
Medicaid Checked? \* No  
Medicaid Status? No Benefits  
Medicaid ID Number  
Provider One ID  
Comments

Main Demographics Address Household Income **Benefits** Insurance Authorized Rep Medical Care Tr

Alert  
It is critical that applicant report enrollment in health benefits programs. Failure to do so may lead to Permanent Removal from the Medication and/or Premium Assistance Programs.

Medicare  
Status \* Active  
Effective Date \*  
Medicare Coverage \*  
Comments  
Medicare Proof of Coverage Document(s)  
Date Type Program Delete Flag  
Medicare Prescription Drug Plan (PDP)  
Status \* No Benefits

Medicaid  
Medicaid Checked? \* No  
Medicaid Status? No Benefits  
Medicaid ID Number  
Provider One ID  
Comments

**NOTE:** Medicare Status field can be set to “No Benefits”, “Active”, or “Applied”.

For each insurance type entered as “Active”, the user get prompted to complete additional required fields (\*) and scan all any required proof of coverage documents not already present.

- Proof of Health Insurance documents previously scanned will be visible.

## Appendix C

**Medicaid** – On the **“Medicaid Status?”** click into the field by clicking the square to the right of the field. In the drop down chose on of the following: If you are unsure of the clients current Medicaid enrollment chose **“No Benefits”** then click **“OK”**. If you believe the client has active Medicaid, chose **“Active”** then put in the current date, then click **“Medicaid Category”** pick list box then click **“Medicaid Status Unknown – WA DOH Please Verify** then click **“OK”**.

**Dialog Medicaid Change**

Medicaid Change

Date Checked \* 10/20/2020

Medicaid Status? \* Active

Date Effective (Active, Applied, Denied) \* 10/20/2020

Medicaid Category

Medicaid ID Number

Provider One ID

Select From View

Please select item(s) from the view.

Code /	Name
Un	Medicaid Status Unknown - WA DOH Please Verify
A01	MCS -State Funded Medical Care Services and ABD Cash with CN Medicaid, Age>65 or Blind/Disabled
A05	MCS -State Funded Medical Care Services; person does not qualify for Medicaid due to Alien status
D01	CN - XIX-SSI Recipient Foster Care/AS/JRA
D02	CN - XIX-Foster Care/Adoption Support/JRA
D26	CN - XIX-Title IV-E Federal Foster Care - Under 26
G03	CN - XIX -Non Institutional Medical - Alternative Living Facility
G95	MN - XIX -Non Institutional in ALF no Spenddown
G99	MN - XIX -Non Institutional in ALF with Spenddown
HWD	CN - XIX -HWD/Healthcare for Workers with Disabilities - S08
K01	CN - XIX-CN Needy MAGI in Medical Institution
K03	ERSO -Undoc Alien MAGI in Medical Institution Emergency Related Service Only
K95	MN - XIX-MAGI based LTC MN no spenddown in Medical Institution
K99	MN - XIX-MAGI based LTC MN spenddown in Medical Institution
L01	CN - XIX -SSI recipient in a Medical Institution, 30 days or more
L02	CN - XIX -SSI Related CN-P in a Medical Institution
L04	ERSO -CN scope -LTC for Non-Citizen in a nursing facility. Limited funding and 45 slots
L21	CN - XIX -COPES / SSI HCB Waiver or Hospice Services
L22	CN - XIX -COPES / SSI HCB Waiver or Hospice Services
L24	ERSO -CN Scope -Alien Long Term Care HCB Waiver

OK Cancel

**Note: DOH will enter the correct Medicaid information.** DOH looks up every client in ACES, which is Medicaid’s database for every Eligibility Assessment.

## Insurance Tab

The Insurance Tab is where a user documents a client’s private insurance information.

When a user marks the insurance type as **“Active”**, additional fields will populate. For each active insurance type, the user will be prompted to complete all appropriate fields and scan all required documents for proofs of coverage.

## Appendix C

The screenshot shows the 'Insurance' tab in a software application. The 'Primary Private Insurance Status' dropdown menu is highlighted with a red box and contains the text 'No Benefits'. A mouse cursor is pointing at the dropdown arrow. Below it, the 'Dental Care Policy Status' dropdown menu is also highlighted with a red box and contains the text 'No Benefits'.

The screenshot shows the 'Insurance' tab with the 'Primary Private Insurance Status' dropdown menu highlighted in red and set to 'Active'. Other fields in the form include 'Effective Date', 'Policy Source', 'Insurance Company Name', 'Policy/Plan Name', 'Medical Coverage?' (set to 'No'), and 'Pharmacy Coverage Included?' (set to 'No'). A table at the bottom has columns for 'Date', 'Type', 'Program', and 'Delete Flag'.

**NOTE: Primary Private Insurance** field Status can be set to “No Benefits”, “Active”, “Applied” or “COBRA”.

Dental Care Policy Section – the **Dental Care Policy Status** field can be set to “No Benefits”, “Active”, “Applied” or “COBRA”.

The screenshot shows the 'Dental Care Policy Status' dropdown menu highlighted in red and set to 'Active'. The 'Plan Name' and 'Comments' fields are visible below it.

- If policy is “Active” → enter the dental care policy name
- If the dental insurance plan name is “Unknown” → type in the source of the dental insurance, “Employer Sponsored”, “Self-Pay”, etc.

---

## Authorized Representative Tab

The **Auth Reps Tab** is where a user documents the number of authorized representatives for the client.

Fill-in the appropriate fields for any/each authorized representative.

# Appendix C

Main Demographics Address Household Income Benefits Insurance **Authorized Rep** Medical Care Team Services Progress Logs

Count  
Number of authorized representatives \* 1

Representative 1  
Name \* bob tree  
Date of Birth 01/01/1980  
Phone (206) 412-3689  
EMail Address

## Medical Tab

The Medical Tab documents a client's medical information, including: current disease stage, identified risk factor(s), and whether the client is on ARV.

To **Add Test Result**, click on the **Add Test Result** button. Fill in the appropriate fields. To save and return back to the Eligibility assessment, click the **Close** button and click **Yes** to save changes.

Eligibility Assessment - Client Services : Kelse Kwaiser/data [03/02/2020]

Main Demographics Address Household Income Benefits Insurance Authorized Rep **Medical** Care Team Services Progress Logs

HIV Status  
Stage of Disease \* HIV Positive AIDS Status Unknown  
Estimated Date HIV Diagnosed  
Identified Risk Factor(s)  
 Blood Transfusion  
 Hemophilia  
 Heterosexual Contact  
 Intravenous Drug Use  
 Men Who Have Sex with Men  
 Mother-at-Risk (Perinatal)  
 Other  
 Undetermined

Currently prescribed antiretroviral therapy? \* Yes  
Date Antiretroviral Therapy Started

HIV Verification  
HIV Verification  
Date Delete Flag / Type  
2017/05/23 N Physician Affidavit

Key Lab Results  
CD4 and Viral Loads  
Add Test Result

Test /	Date	Result	Source	Scan Doc?
CD4 Count	2019/03/04	409	Surveillance Interface	No
CD4 Count	2018/08/01	805	Surveillance Interface	No
CD4 Count	2018/04/17	666	Surveillance Interface	No
CD4 Count	2017/11/20	693	Surveillance Interface	No
CD4 Count	2017/07/24	732	Import	No

# Appendix C

## Care Team Tab

The **Care Team Tab** is where a user can monitor and enter a client's primary care team, an HIV Care Physician and a HIV Case Manager.

Fill in the appropriate fields. To save and return back to the Eligibility assessment, click the **Close** button and click **Yes** to save changes

Main Demographics Address Household Income Benefits Insurance Authorized Rep Medical **Care Team** Services Progress Logs

HIV Care Physician  
Clinic/Facility/Practice where Client receives HIV Medical Care \* Swedish Family Medicine  
Physician providing HIV Medical Care \*

HIV Case Manager  
HIV Case Management Agency \* Pierce County AIDS Foundation  
HIV Case Manager \*

## Services Tab

The **Services Tab** will be a summary of the Medication Assistance Enrollment Records, Premium Assistance Enrollment Records, and Eligibility History. Once this form is completed, an enrollment record will be created.

Fill in the fields as appropriate. Depending on how fields are completed, additional fields may populate.

Main Demographics Address Household Income Benefits Insurance Authorized Rep Medical Care Team **Services** Progress Logs

Current Status

Medication Assistance Enrollment Records

Date Effective	Date End	Status	Benefit Level	Share Amount	Deleted?
----------------	----------	--------	---------------	--------------	----------

Premium Assistance Enrollment Records

Date Effective	Date End	Status	Policy Type	Carrier	Plan Name	Deleted?
----------------	----------	--------	-------------	---------	-----------	----------

Categorically eligible for Expanded Medicaid? \* No

Mandatory ACA? No

Mandatory Insurance? No

Mandatory Medicaid? No

Mandatory Medicare B? No

Mandatory Medicare D? No

Medication Assistance

Do you want to add/continue Medication Assistance? \* Yes

Insurance Enrollment Assistance

Does Client want assistance enrolling in a Health Insurance Policy? \* No

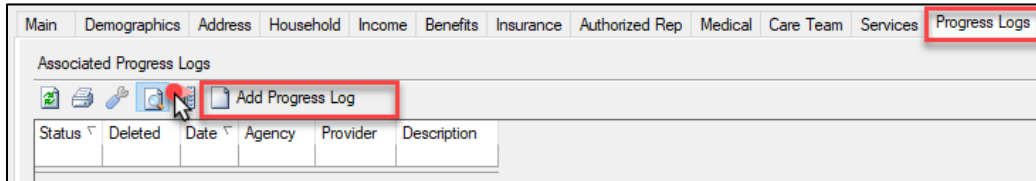
Primary Private Insurance

Does Client wish to add/continue Premium Assistance on their existing Insurance Policy? \* No

## Progress Logs Tab

The **Progress Log Tab** is where **Eligibility Assessment** related progress logs can be entered. The **Progress Log** is designed to capture the date and time and number of minutes that a provider spent working with or on behalf of a client. Notes of the encounter/effort should be documented.

To create a Progress Log, click on the **Add Progress Log** button.



- It is not required, but a user can also enter an appointment, lab result, or referral from the Progress Log form.

To save a **Progress Log** as “In Progress” or as “Complete”:

- “In Progress” → to save the **Progress Log** as “In Progress”, click the **Close** button and click **Yes** to save changes

Status ▾	Deleted	Date ▾	Agency	Provider	Description
In Progress	N	2020/08/28	Lifelong	Kelse Kwaiser	Test- Eligibility Assessment

- “Completed” → to save the **Progress Log** as “Completed”, click on the green **Complete** button.

Status ▾	Deleted	Date ▾	Agency	Provider	Description
Complete	N	2020/08/28	Lifelong	Kelse Kwaiser	Test- Eligibility Assessment



Once a **Progress Log** is marked as “**Completed**”, it is no longer editable.

## Save Eligibility Assessment “In Progress”

To save the **Eligibility Assessment** as “**In Progress**”, click the **Close** button and click **Yes** to save changes.

Date Submitted	Status	Delete Flag	Source	Submitted By	Checked Out?	Checked Out By
	In Progress	N	ADAP		Yes	Kelse Kwaiser

The **Eligibility Assessment** will remain “**Checked-Out**” by the user who saves it in the “**In Progress**” status .

To view client specific **Eligibility Assessments**, navigate to the **Client Profile** > click the green **View** button > select **Eligibility Assessments**

## Submit Eligibility Assessment

An **Eligibility Assessment** must be submitted before it can be completed. After the **Eligibility Assessment** is completed it will be reviewed and processed by DOH.

To **Submit** an Eligibility Assessment, click on the green **Submit** button.

Date Submitted	Status	Delete Flag	Source	Submitted By	Checked Out?	Checked Out By
2020/08/28	Submitted	N	ADAP	Kelse Kwaiser	Yes	Kelse Kwaiser

- **NOTE:** All users who are able to create an Eligibility Assessment will be able to submit and complete the Eligibility Assessment - however only DOH can **process** Eligibility Assessments.

## Complete Eligibility Assessment

The **Eligibility Assessment** must be completed before it can be reviewed and processed by DOH.

Double click the **Eligibility Assessment** to open the record, and click the “**Edit**” button.



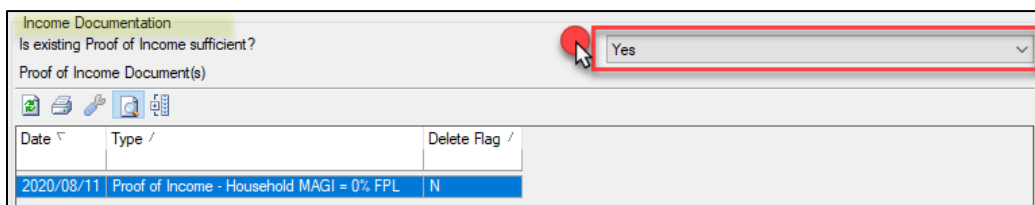
## Appendix C



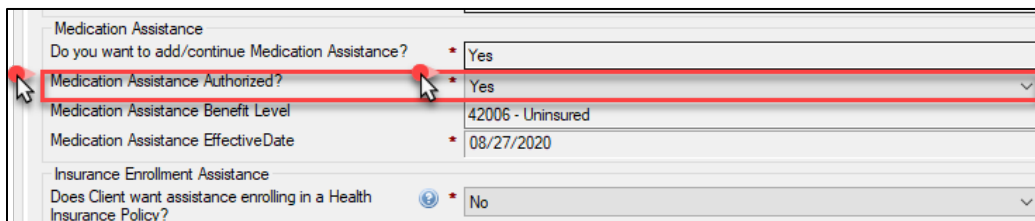
Complete any missing required fields (\*) and add any missing health information documents/scans, such as address, income, identity, etc.

- **NOTE:** an **Eligibility Assessment** cannot enter “**Completed**” status until all the required health information documents/scans are entered. If a user attempts to complete with missing documents, they will receive an error message specifying exactly what documents are missing.

After adding all the required health information documents/scans, the user will need to navigate back to the **Main, Address, Income, Benefits, and Medical** Tabs complete a newly populated question on each tab: “**Is existing [document name] documentation sufficient?**”

A screenshot of a form titled 'Income Documentation'. The question 'Is existing Proof of Income sufficient?' is followed by a dropdown menu with 'Yes' selected. Below this is a section for 'Proof of Income Document(s)' with a table. The table has columns for 'Date', 'Type', and 'Delete Flag'. One row is visible with the date '2020/08/11', the type 'Proof of Income - Household MAGI = 0% FPL', and a delete flag 'N'. A red box highlights the dropdown menu.

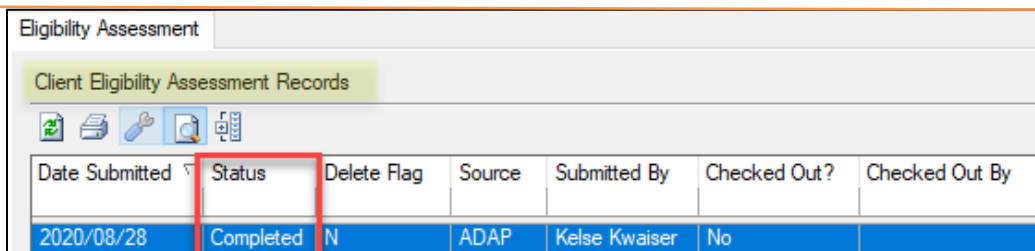
On the **Services** Tab, complete the question “**Do you want to add/continue Medication Assistance?**”

A screenshot of a form titled 'Medication Assistance'. The question 'Do you want to add/continue Medication Assistance?' is followed by a dropdown menu with 'Yes' selected. Below this are other questions: 'Medication Assistance Authorized?' (dropdown with 'Yes'), 'Medication Assistance Benefit Level' (text field with '42006 - Uninsured'), and 'Medication Assistance EffectiveDate' (text field with '08/27/2020'). A red box highlights the first dropdown menu.

To **Complete** an Eligibility Assessment, click on the green **Complete** button.



After completing the **Eligibility Assessment** the status will change from “**Submitted**” to “**Completed**”.

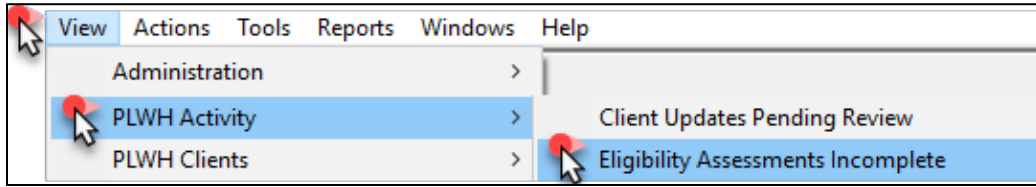


Date Submitted	Status	Delete Flag	Source	Submitted By	Checked Out?	Checked Out By
2020/08/28	Completed	N	ADAP	Kelse Kwaiser	No	

### Eligibility Assessment View - All

# Appendix C

To view **Incomplete Eligibility Assessments**, click the grey **View** button (main toolbar) > **PLWH Activity** > select **Eligibility Assessments Incomplete**.

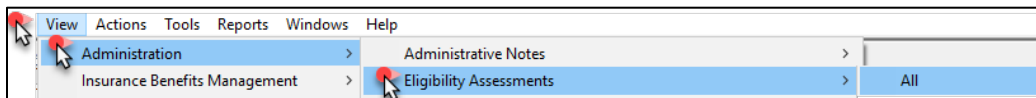


## Eligibility Assessment View – Administrators



Specific agency representatives assigned administrative roles can view “**In Progress**”, “**Submitted**”, and “**Completed**” Eligibility Assessments.

- Click the grey **View** button (main toolbar) > select **Eligibility Assessments\All**



- Expand status categories by clicking on the box next to the status title.

A screenshot of the 'Provide Enterprise - [PLWH Activity\Eligibility Assessments Incomplete]' window. The window displays a table with columns: Status, Date Due, Date Received, Deleted, Type, Urgent?, Interim, Client Flag, Checked Out?, Checked Out By?, Last Name, and First Name. The 'In Progress' status category is expanded, showing two rows of data. The 'Submitted' status category is also expanded, showing two rows of data.

Status	Date Due	Date Received	Deleted	Type	Urgent?	Interim	Client Flag	Checked Out?	Checked Out By?	Last Name	First N
In Progress	2019/12/03	2019/09/01	N	Reassessment	No	Yes	Existing Client	Yes			
In Progress	2020/10/26	2020/08/27	N	New Assessment	No	No	Existing Client	No			
Submitted	2019/09/30	2019/09/01	N	Priority Reassessment	No	No	Existing Client	Yes			
Submitted	2019/10/11	2019/09/11	N	Reengagement	No	No	Existing Client	Yes			
Submitted	2019/10/24	2019/09/24	N	Reassessment	No	No	Existing Client	No			

- To close all or expand all status categories by clicking on the green and red expansion and collapse options:



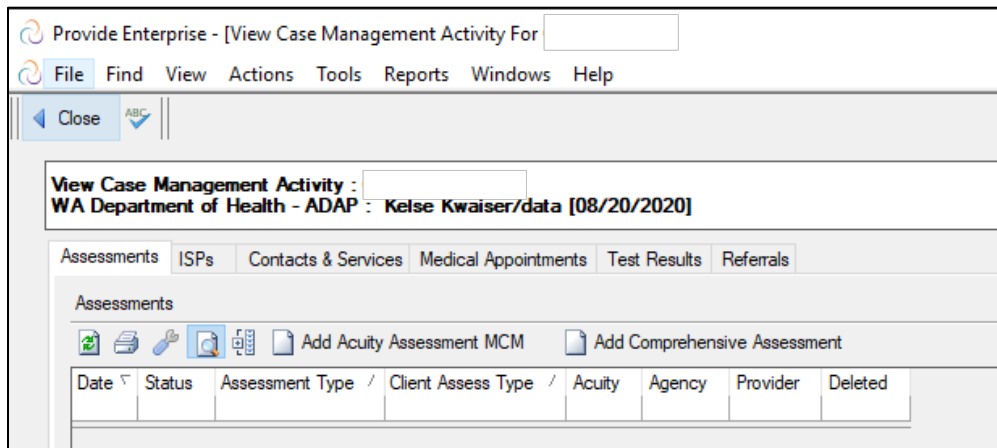
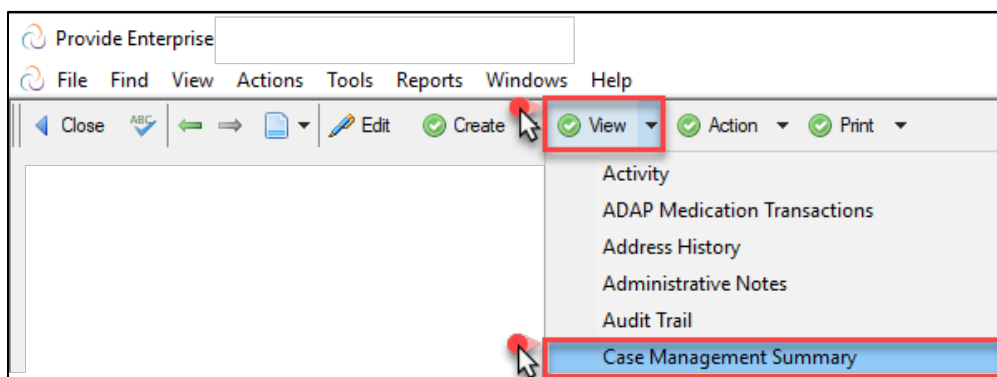
## Appendix C

### Provide® Enterprise System PLWH Case Management Manual

After searching and locating a client in Provide, navigate to the Client Profile by double clicking on the client record. The Client Profile is where medical and non-medical case managers can access the **Case Management Summary** view.

The **Case Management Summary** view is where medical and non-medical case managers will perform day-to-day service management and reporting tasks.

From the Client Profile, navigate to the Case Management Summary by clicking on the green **View Button > Case Management Summary** (image below).

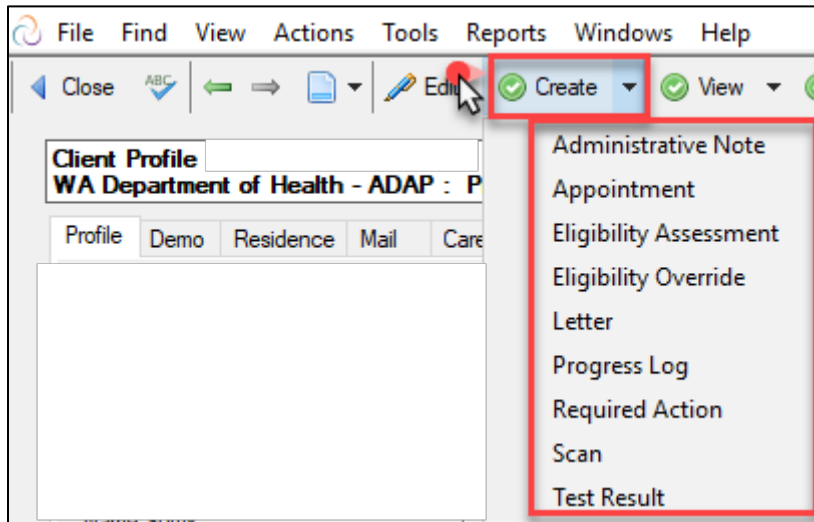


In the **Case Management Summary** view (image above), a case manager can create, update and view a number of things including:

- **Assessments**
- **ISPs**
- **Contracts & Services (Progress Logs & Services Provided)**
- **Medical Appointments**
- **Test Results**
- **Referrals**

## Appendix C

Many of these activities can also be accessed by clicking the green **Create** button within the Client Profile and/or within the **Case Management Summary**.



When entering data into tabs and forms – **only fields with red asterisks (\*) are required** to save and/or complete.

## Add Acuity Assessments MCM

To create an **Acuity Assessment MCM**, navigate to: **View > Case Management Summary View > Assessments Tab > Add Acuity Assessment MCM**

The **Acuity Assessment MCM** form contains the following tabs:

- Acuity Assessment MCM Tab**

The screenshot shows the 'Acuity Assessment MCM' form with two tabs: 'Acuity Assessment MCM' (selected) and 'Score'. The form is divided into three sections for Acuity Level 1, 2, and 3, each with a 'Select all' option. Each section contains a list of checkboxes representing different assessment criteria. Red circles highlight the 'Select all' radio buttons for each level, and a red arrow points to the 'Acuity Assessment MCM' tab.

Acuity Level	Assessment Criteria
Acuity Level 1 (Select all)	<input checked="" type="checkbox"/> In Progress <input checked="" type="checkbox"/> Newly Diagnosed (w/in 6 months) <input type="checkbox"/> Unsuppressed Viral Load greater than 200 copies <input type="checkbox"/> Not in HIV care <input type="checkbox"/> Not on ARV's (if recommended) <input type="checkbox"/> Not adherent to ARV's <input type="checkbox"/> Justice Involved in past 6 months <input type="checkbox"/> Not adherent to HIV medical appointments <input type="checkbox"/> Pregnant <input type="checkbox"/> No access to ARV's <input type="checkbox"/> Medical emergency/hospitalization <input type="checkbox"/> Other medical conditions not addressed (i.e. Hepatitis C, diabetes) <input type="checkbox"/> None of the above
Acuity Level 2 (Select all)	<input checked="" type="checkbox"/> Isolation <input type="checkbox"/> No insurance or incomplete or insufficient coverage <input type="checkbox"/> Unstable housing or homeless <input type="checkbox"/> Current domestic violence and/or abuse <input type="checkbox"/> Unmet or unaddressed Mental health needs <input type="checkbox"/> Current or historical substance abuse <input type="checkbox"/> Financial needs identified (i.e. utility assistance, HOPWA, etc.) <input type="checkbox"/> Linguistic challenges <input type="checkbox"/> Legal issues impeding other areas of life <input type="checkbox"/> Transportation needs <input type="checkbox"/> Income insufficient to meet needs <input type="checkbox"/> Needs frequent assistance navigating systems <input type="checkbox"/> No stable support network <input type="checkbox"/> Current IDU <input type="checkbox"/> Failed to reach client after three attempts <input type="checkbox"/> None of the above
Acuity Level 3 (Select all)	<input checked="" type="checkbox"/> Current viral suppression maintained for minimum of 6 months <input type="checkbox"/> Adherent to HIV medical appointments <input type="checkbox"/> Enrolled in comprehensive coverage <input type="checkbox"/> Without significant vulnerabilities regarding life domain stability <input type="checkbox"/> Reliable access to transportation <input type="checkbox"/> Steady, sufficient source of income <input type="checkbox"/> No unmet mental health needs <input type="checkbox"/> No current Substance Abuse <input type="checkbox"/> None of the above

- Score Tab**

The screenshot shows the 'Score' tab of the 'Acuity Assessment MCM' form. It features a 'Score' field with a red arrow pointing to it, and two text input fields: 'Acuity Level' and 'Assessment Comments'.

The **Score** Tab does not require data entry – assessment comments are optional and the acuity level is calculated automatically based on the answers provided on the **Acuity Assessment MCM** Tab.

## Appendix C

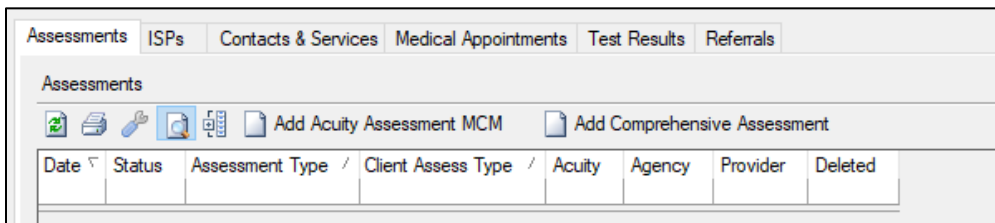
After entering data, the Assessment can be **Saved in Progress** or **Completed**.

- **“In Progress”** → to save the assessment with the status **“In Progress”** click either Close > Save or click the **Save in Progress** button.
- **Completed** → if all the required fields (\*) are entered the assessment can be saved with a **Completed** status by clicking the green **Completed** button with the green checkmark icon.

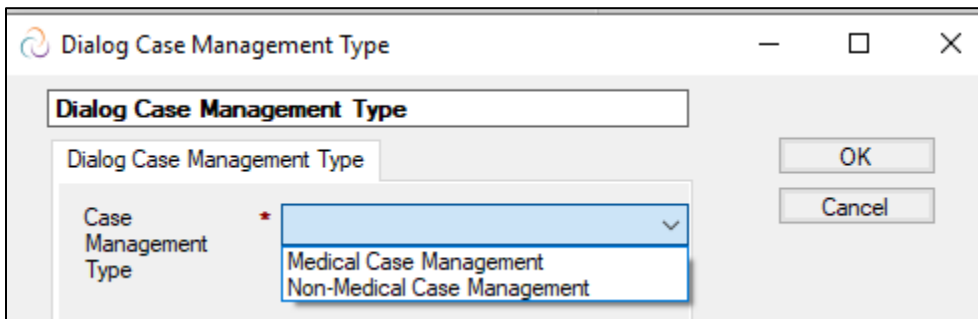


### Add Comprehensive Assessment

To create a **Comprehensive Assessment**, navigate to **View > Case Management Summary View > Assessments Tab > Add Comprehensive Assessment**



On the **Status** Tab of the **Comprehensive Assessment** form, enter the **Case Management Type** field by clicking on the drop-down menu and indicating if the **Comprehensive Assessment** is a **Medical Case Management** or **Non-Medical Case Management** assessment.



After selecting the **Case Management Type**, complete the **Assessment Class** field to inform whether this is an initial or subsequent assessment. Click **OK**.

The **Comprehensive Assessment** form contains the following tabs:

- **Status**
- **Medical**
- **Other Core Services**

# Appendix C

- Support Services
- Sexual Health
- Quality of Life
- Domestic Violence
- Summary

Fill the additional tabs as appropriate. Below are previews of each tab in the Comprehensive Assessment with required fields circled in red:

- **Status Tab**

Assessment Status: In Progress  
Assessment Type: Medical Case Management  
Assessment Class: Initial

- **Medical Tab**

Overall Health: [Red Circle]  
Physician treating HIV?: [Red Circle]  
CD4 Count and Viral Load Test Results

Test /	Date ▾	Result
CD4 Count	2015/09/17	450
HIV 1 Viral Load	2015/09/17	20

CD4/Viral Load Comments

Taking medication as prescribed?: [Red Circle]  
Pharmacy  
Pharmacy Phone Number  
Concerns about being prescribed HIV medications?: [Red Circle]  
Current Drug Protocol

Date Started ▾	Drug Name	Strength	Measure	Route
----------------	-----------	----------	---------	-------

Drugs Comments

Recent Medical Appointments

Date /	Status	Provider
--------	--------	----------

Medical Appointment Comments

- **Other Core Services Tab**

# Appendix C

Other Core Services

Mental health concerns? \*

Taking medications as prescribed? \*

Depression \*

Drug or alcohol use and/or abuse \*

Dental Needs \*

Dental visit in past year? \*

Eating habits over the last month \*

Need for Nutritional Counseling? \*

Vision Needs \*

Other Core Services Comments

- **Support Services Tab**

Support Services

Housing, mortgage, utility, and/or emergency financial assistance needed? \*

Support Group needed? \*

Would you like to work with a peer navigator? \*

Legal needs? \*

Food Bank/Home Delivered Meal needs? \*

Rehabilitation/Job/Education needs? \*

Transportation needs? \*

Support Services Comments

- **Sexual Health Tab**

Sexual Health

Knowledge of HIV \*

Knowledge of HIV Medications and how they affect HIV \*

Risk assessment completed in last six months \*

Diagnosis of STD in last 12 months \*

Partner Notification assistance needed \*

Sexual Health Comments

- **Quality of Life Tab**

Quality of Life

Managing monthly bills \*

Cultural factors? \*

Linguistic factors? \*

Adaptive Equipment Needed? \*

Needs Assist with ADL's? \*

Any Religious or Spiritual affiliations? \*

Quality Of Life Comments

- **Domestic Violence Tab**





# Appendix C

- **Summary Tab**

After entering data, a **Comprehensive Assessment** can be **Saved in Progress** or **Completed**.

- **“In Progress”** → to save the assessment with the status **“In Progress”** click either the **Close** button and click **Yes** to save, or click on the **Save in Progress** button.
- **Completed** → if all the required fields (\*) are entered the assessment can be saved with a **Completed** status by clicking the green **Answers Completed** button with the green checkmark icon.

To review or re-open the assessments after starting/completing them, a user needs to click the refresh button  and  on assessment to reopen the record.

Assessments							
Date	Status	Assessment Type	Client Assess Type	Acuity	Agency	Provider	Deleted
2020/08/25	Completed	Acuity Assessment MCM		3	Lifelong	Kelse Kwaiser	N
2020/08/25	Answers Completed	Comprehensive Assessment	Medical Case Management		Lifelong	Kelse Kwaiser/LL	N

**Note:** Deleted records are indicated by a **“Y”** in the **Deleted** column. The records in the above image are not deleted, indicated by the **“N”** in the **Deleted** column.

## ISPs

To create an **ISP**, navigate to **View > Case Management Summary View > ISPs Tab > Add ISP**

## Appendix C

The screenshot shows the top portion of a software interface. At the top, there are several tabs: 'Assessments', 'ISPs', 'Contacts & Services', 'Medical Appointments', 'Test Results', and 'Referrals'. The 'ISPs' tab is selected and highlighted with a red circle. Below the tabs is a toolbar with several icons, including a document with a plus sign, a printer, a hand, a magnifying glass, and a document with a plus sign. The 'Add ISP' icon is highlighted with a red circle. Below the toolbar is a table with the following columns: 'Date Opened', 'Status', 'Type', 'Counselor', 'Date Last Review', 'Date Closed', and 'Deleted'.

Double click on the **Add ISP** form and enter the **Case Management Type** field by clicking on the drop-down menu and indicating if the ISP is associated with **Medical Case Management** or **Non-Medical Case Management**.

The screenshot shows a dialog box titled 'Dialog Case Management Type'. It has a title bar with a close button. The dialog contains a text input field with the text 'Dialog Case Management Type'. Below this is a dropdown menu labeled 'Case Management Type' with a red asterisk next to it. The dropdown menu is open, showing two options: 'Medical Case Management' and 'Non-Medical Case Management'. To the right of the dropdown are two buttons: 'OK' and 'Cancel'.

After selecting the **Case Management Type**, complete the **Assessment Class** field to inform whether this is an initial or subsequent assessment. Click **OK**.

The **ISP** form contains the following tabs:

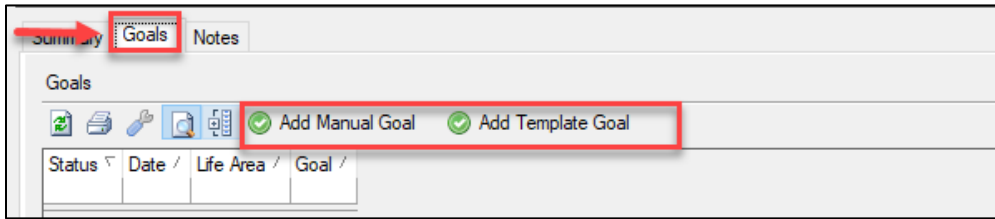
- **Summary**
- **Goals**
  - **Add Manual Goal**
  - **Add Template Goal**
- **Notes**

Fill the additional tabs as appropriate. Below are previews of each tab in the ISP with required fields circled in red:

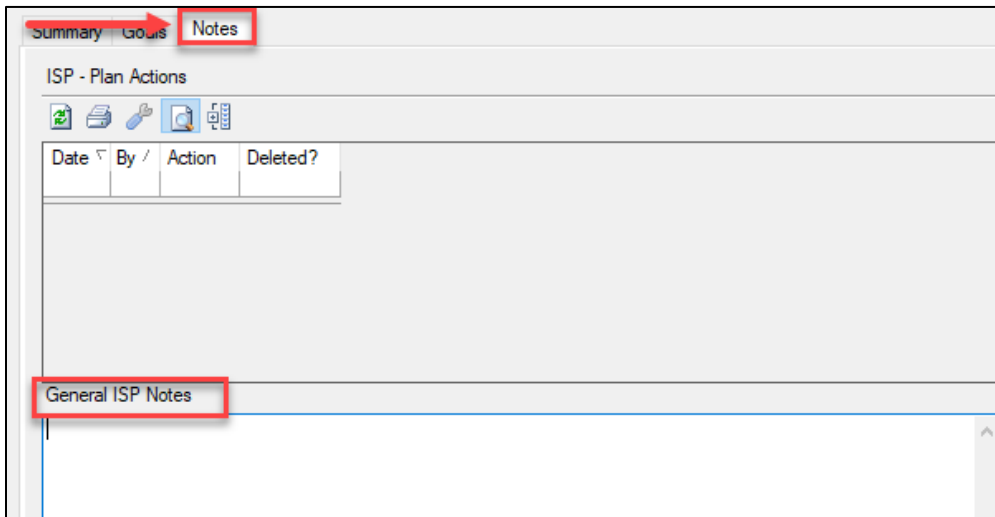
- **Summary Tab**

The screenshot shows the 'Summary' tab of the ISP form. The 'Summary' tab is selected and highlighted with a red box and a red arrow. The form contains several fields: 'ISP Status' (Open), 'Case Manager/Counselor' (Kelse Kwaiser), 'ISP Type' (Medical Case Management), 'Was Client provided copy of Plan?' (Yes), 'Did Client Sign Plan?' (Yes), and 'Date Opened' (08/26/2020). The 'ISP Type' field is circled in red.

- **Goals Tab**



- **Notes Tab**



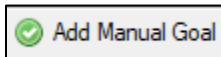
---

## ISP Goals

Manual Goals and Template Goals are added to and associated with ISPs. Manual Goals are developed between individual Case Managers and Clients. Template Goals are developed by a workgroup of Case Management providers to be available for all Case Managers to add to ISPs.

### Manual Goals:

- To **Add Manual Goal** to an ISP, follow these steps:
  1. Navigate to the **Goals** Tab within the ISP
  2. Click the green **Add Manual Goal** button



3. Fill in fields as appropriate:

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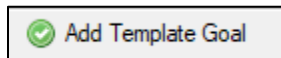
- **Goal Category** – category that matches the goal the user is adding to the ISP (ex: Access, Adherence, Retention, etc.)
- **Goal Life Area** – the life area this goal most closely relates to.
- **Goal Statement** – a brief summary describing the goal.
- **Interventions** – a list of specific interventions that will be followed in working towards meeting this goal

#### 4. When finished:

- To save and add an additional goal → click **Save and Create Another** to add an additional goal
- To save the goal but not complete the goal → click **Close** and **Yes**
- To close/complete goal → click **Close ISP Goal**

#### Template Goals:

- To Add Template Goal to ISP:
  1. Navigate to the **Goals** Tab within the ISP
  2. Click the green **Add Template Goal** button



3. Select a template from the active list of templates available to add/auto-fill fields

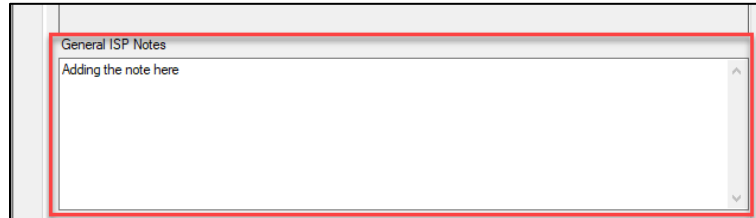
Status	Life Area	Name
<b>Active</b>		
Support		
Active	Support	Assess employment background and current ability to obtain employment and refer for vocational services if appropriate.
Active	Support	Assess financial needs and develop plan to address low/no income.
Active	Support	Budget Counseling required.
Active	Support	Client has a self identified need for food bank/home-delivered meal services.
Active	Support	Client is pregnant, needs immediate referral to physician for prenatal care.
Active	Support	Continue good oral health care habits.
Active	Support	Continue to provide supportive HIV education.

## ISP Notes

**Notes** Tabs exist on both on the main page of an ISP and within ISP goal forms.

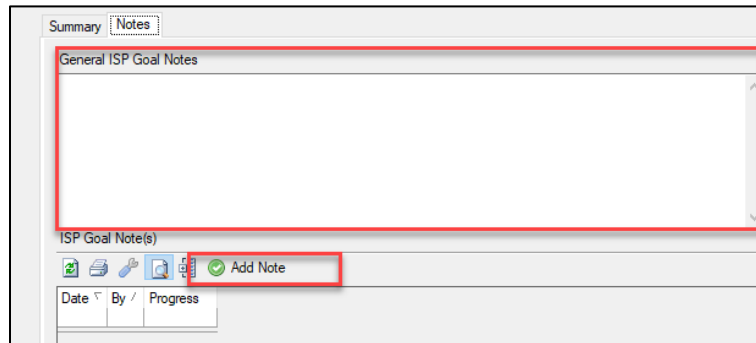
- **ISP Notes:**

The **Notes** Tab on the main page of an ISP only allows for manual entry of notes into the **General ISP Goal Notes** free-type field



- **ISP Goal Notes:**

The **Notes** Tab within ISP goal forms allow for either manual entry of notes into the **General ISP Goal Notes** free-type field or adding a note by clicking the green **Add Note** button



## Completing the ISP

Once goals are added to the **ISP**, it is important to mark the plan as **Completed** with the client.

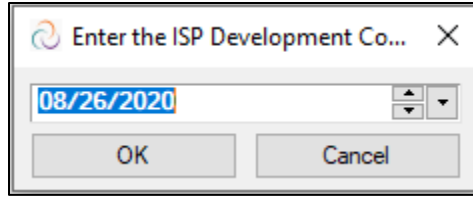
**NOTE:** The **ISP** will not be counted in reporting unless it is in a completed status. To **Complete** the **ISP**, follow the steps below:

1. At the top of the ISP page, click on the **Plan Development Completed** button.



2. A dialog box similar to the below image will appear:

## Appendix C



3. Enter the date the **ISP** was completed with the client and click the **OK** button.
4. The **ISP** status will change from **Open** to **Completed**.

---

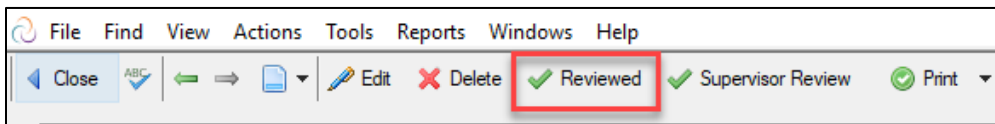
### Reviewing the ISP

Once the **ISP** has been marked as **Completed**, the user can review the **ISP**.

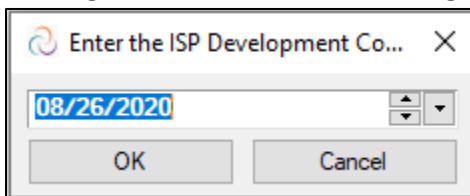
A user can mark an **ISP** as **Reviewed** to certify that they reviewed the **ISP** with the client and made implemented any necessary updates or adjustments.

To mark the **ISP** as **Reviewed**, follow the steps below:

1. At the top of the **ISP** page, click on the **Reviewed** button.



2. A dialog box similar to the below image will appear:



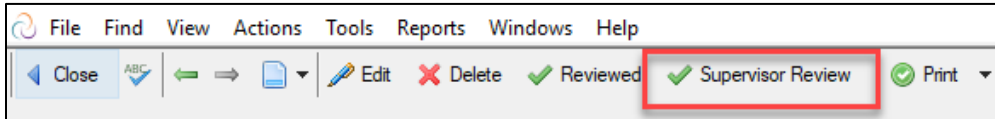
3. Enter the date the **ISP** was reviewed with the client and click the **OK** button
4. The **ISP** status will change from **Completed** to **Reviewed**.

## Supervisor Review of the ISP

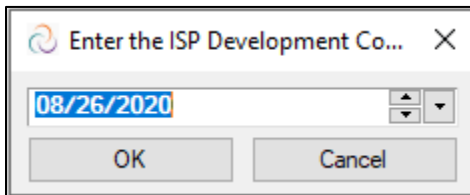
Once the **ISP** has been marked as Completed, the Supervisor will be available to document their review of the **ISP**. Only supervisors will be able to do a supervisor review.

To mark the **ISP** as having been reviewed by the supervisor, follow the steps below:

1. At the top of the **ISP** page, click on the **Supervisor Review** button.



2. A dialog box similar to the below image will appear:



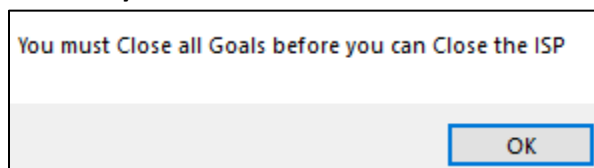
3. Enter the date the **ISP** was reviewed by the supervisor and click the **OK** button.

## Closing the ISP

The **ISP** should only be closed when the client is being discharged from an agency's service and/or if the client is being transferred to another agency.

To close the **ISP**, follow the steps below:

1. At the top of the **ISP** page, click **Edit** and then click the **Close ISP** button
2. If a user has not closed any **ISP Goals**, a dialog box will appear that says, "You must Close all Goals before you can Close the ISP."



- When a user get this message, they need to click the **OK** button to return to the **ISP**.
- Double click into each open **ISP Goal**.
- Click on the **Edit** button and then click on the **Close ISP Goal** button. The goal will be closed and three additional fields will appear:
  - **Actual Resolution Date:** Enter the date the goal is being closed
  - **Outcome Measure:** Enter the reason the goal is being closed
  - **Outcome Comments:** Enter any comments relative to why the goal is being closed

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- Once all **ISP Goals** have been closed, click on the **Close ISP** button. Additional fields will appear on the **Summary** Tab of the **ISP**, including:
  - Date Closed:** Enter the date the **ISP** is being closed
  - Reason Closed:** Enter the reason the **ISP** is being closed
- When finished, click the **Close** button and then **Yes** to save changes

---

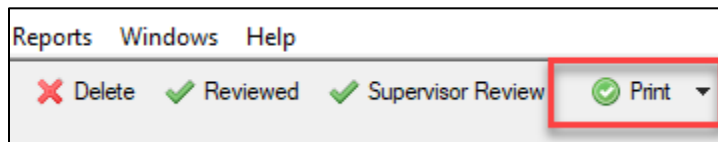
### Updating the ISP

To update the **ISP** double click into the **ISP** and click the **Edit** button.

---

### Printing the ISP

To print the **ISP**, click on the **Print** button.



Select either:

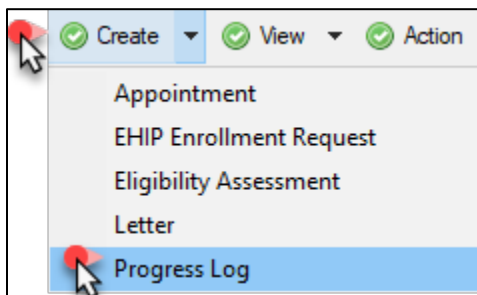
- Print the **ISP** (print only open goals) or
- Print the **Entire Plan** (print all goals).

---

### Progress Logs

The **Progress Log** is designed to capture the date and time and number of minutes that a provider spent working with or on behalf of a client. Notes of the encounter/effort should be documented. Below are 2 avenues a user can navigate down to create a **Progress Log**:

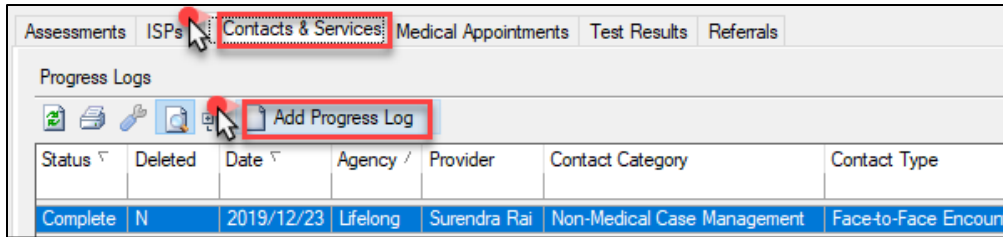
- From Client Profile** → click the green **Create** button > click on **Progress Log** (see image below).



- From **Client Profile** > click **View** > **Case Management Summary** > navigate to the **Contacts & Services** Tab > click the **Add Progress Log** form (see image below).



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Using either of the options above allow a user to create a **Progress Log**.

**Progress Log :**  
**Lifelong - Client Services : Kelse Kwaiser/LL [08/26/2020]**

Summary | Appointments | Labs | Referrals | Services

Status \* In Progress  
Provider \* Kelse Kwaiser  
Date \* 08/26/2020  
Minutes \*  
Contact Category \*  
Contact Type  
Funding Source  
Service(s)  
Brief Description \*

The **Progress Log** form contains the following tabs:

- **Summary**
- **Appointments** (optional)
- **Labs** (optional)
- **Referrals** (optional)
- **Services** (optional)

Fill in the appropriate/required fields on the **Summary** Tab. It is **not** required, but a user may also add an appointment, lab result, or referral in their corresponding tabs.

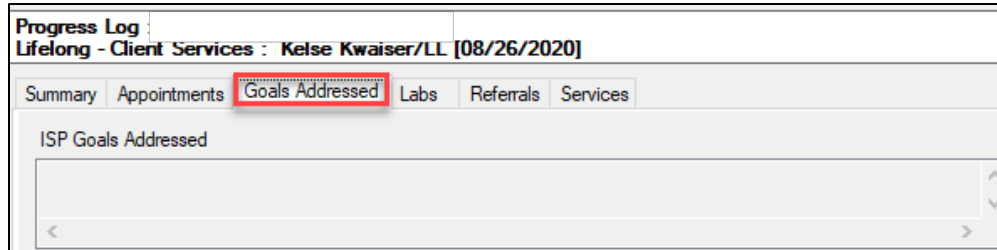
**Progress Log :**  
**Lifelong - Client Services : Kelse Kwaiser/LL [08/26/2020]**

Summary | Appointments | Labs | Referrals | Services

Status \* In Progress  
Provider \* Kelse Kwaiser  
Date \* 08/26/2020  
Minutes \*  
Contact Category \*  
Contact Type  
Funding Source  
Service(s)  
Brief Description \*  
Full Description

## Appendix C

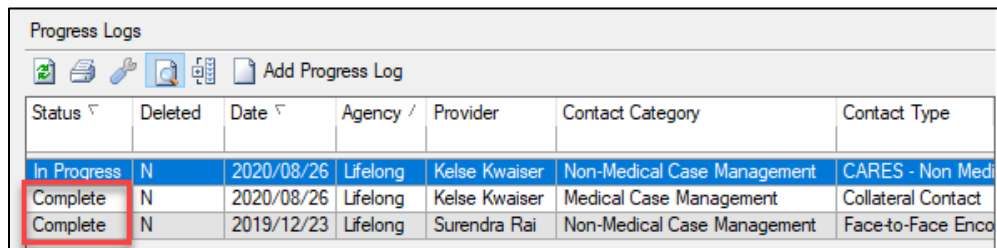
The **Contact Category** the user enters on the **Summary** Tab will determine whether a **Goals Addressed** Tab will populate in the **Progress Log**. The **Goals Addressed** Tab allows a user to select the **ISP Goals** addressed during this specific client encounter.



The screenshot shows a web interface for a Progress Log. At the top, it says "Progress Log" and "Lifelong - Client Services : Kelse Kwaiser/LL [08/26/2020]". Below this are several tabs: "Summary", "Appointments", "Goals Addressed" (which is highlighted with a red box), "Labs", "Referrals", and "Services". Under the "Goals Addressed" tab, there is a section titled "ISP Goals Addressed" with a scrollable area below it.

### Marking Progress Logs as “Completed”

When finished completing the **Progress Log**, click on the green **Complete** button to complete the **Progress Log**.



The screenshot shows a table titled "Progress Logs" with several icons at the top (Add, Print, Edit, etc.) and an "Add Progress Log" button. The table has the following columns: Status, Deleted, Date, Agency / Provider, Contact Category, and Contact Type. There are three rows of data:

Status	Deleted	Date	Agency / Provider	Contact Category	Contact Type
In Progress	N	2020/08/26	Lifelong / Kelse Kwaiser	Non-Medical Case Management	CARES - Non Medi
Complete	N	2020/08/26	Lifelong / Kelse Kwaiser	Medical Case Management	Collateral Contact
Complete	N	2019/12/23	Lifelong / Surendra Rai	Non-Medical Case Management	Face-to-Face Enco



Once a **Progress Log** is marked as “**Complete**”, a user cannot edit the **Progress Log**. If need be, a user can mark a “**Complete**” **Progress Log** as “**Deleted**”

### Marking Progress Logs as “In Progress”

If a user does not have time to enter in all the required information in one sitting, they can save the **Progress Log** as “**In Progress**” so they can come back to it later. To save it as “**In Progress**” click on the **Close** button and then **Yes** to save changes. When a user wants to come back and complete the **Progress Log**, double click into the “**In Progress**” **Progress Log** and click on the **Edit** button.

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Status	Deleted	Date	Agency	Provider	Contact Category	Contact Type
In Progress	N	2020/08/26	Lifelong	Kelse Kwaiser	Non-Medical Case Management	CARES - Non Medi
Complete	N	2020/08/26	Lifelong	Kelse Kwaiser	Medical Case Management	Collateral Contact
Complete	N	2019/12/23	Lifelong	Surendra Rai	Non-Medical Case Management	Face-to-Face Endo



**It is important to complete each Progress Log – records that are not in a “Completed” status are not included in reports.**

A user can see a list of all the “In Progress” Progress Logs at **View > PLWH Activity > Progress Logs in Progress**.

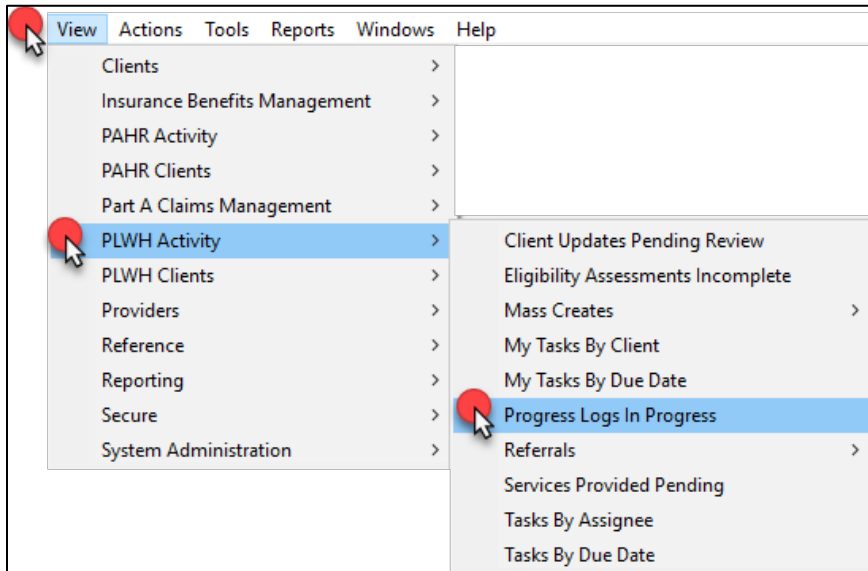
## Mass Completing Progress Logs

If a user closes and saves a **Progress Log** without completing it, the **Progress Log** will be left in the “In Progress” status.

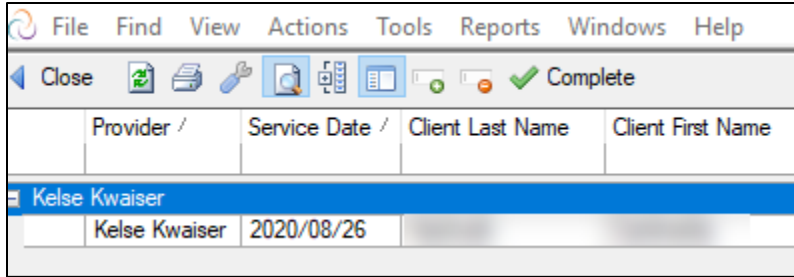


It is important to complete each **Progress Log** so they count in reports. There is a view in Provide where a user can see all of the “In Progress” Progress Logs. In this view, a user can also **mass complete** the “In Progress” Progress Logs. This is a time-saver and prevents a user from going back into each client profile individually to complete their Progress Log.

Navigate to **View > PLWH Activity > Progress Logs in Progress** to see a view similar to this:

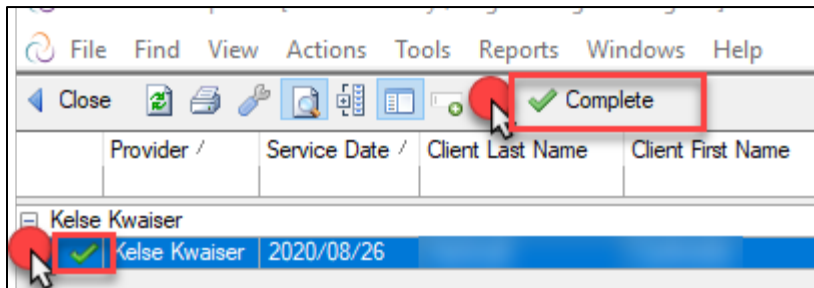


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Provider /	Service Date /	Client Last Name	Client First Name
Kelse Kwaiser			
Kelse Kwaiser	2020/08/26		

Click to the left of **Progress Log** records to mass select records. This action will place a green check mark next to each record the user wants to mark as **Completed** (see image below).



Provider /	Service Date /	Client Last Name	Client First Name
Kelse Kwaiser			
<input checked="" type="checkbox"/>	Kelse Kwaiser	2020/08/26	

After mass selecting records to complete, click on the green **Complete** button. Provide will check through all selected records to confirm:

1. All the required fields (\*) are entered on every record selected for closure.
2. The client is indeed eligible for the service documented in the Progress Log.

If the above checks out, the record will get completed and disappear from this view. If the above does not check out, the record will not be completed and remain **"In Progress"**.

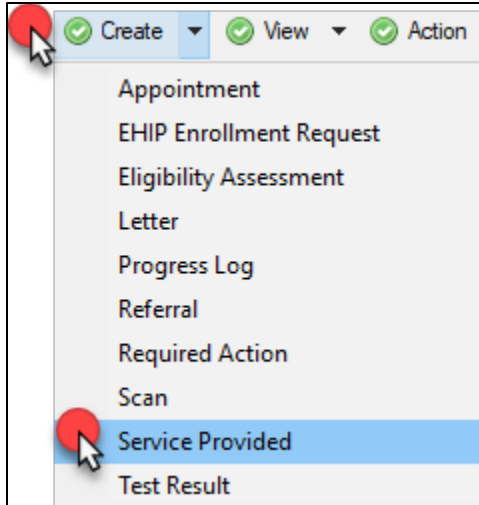
---

## Services Provided

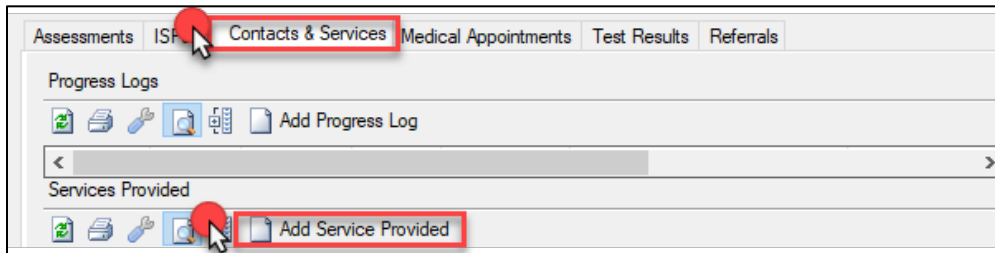
**Services Provided** records document tangible services that a Case Manager provided to a client. Below are 2 avenues a user can navigate down to create a **Services Provided**:

1. **From Client Profile** → click the green **Create** button > click on **Services Provided** (see image below).

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2. From **Client Profile** > click **View** > **Case Management Summary** > navigate to the **Contacts & Services** Tab > click the **Services Provided** form (see image below).



Using either of the 2 options above allow a user to create a **Services Provided**. Fill in the appropriate fields. Data entry fields will vary depending on the **Service Provided** entered.

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Close ABC | Complete Not Provided Link to Client Profile

Service Provided : Cantinerita Aardvark (18871)  
Lifelong - Client Services : Kelse Kwaiser/LL [08/26/2020]

Service Provided

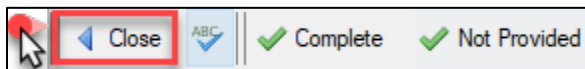
Status	* Pending
Provider	* Kelse Kwaiser
Service Date	* 08/26/2020
Service Category	*
Service Provided	*
Funding Source	*
Units of Service	
Unit of Measure	
Unit Cost of Service	
Total Cost of Service	\$0.00
Comments	

Lifelong  
Service Comment  
DSS  
PDI File ID  
Notes

When finished, you can either mark the service as **“Completed”** **“Pending”** or **“Not Provided”**.

### Marking Service Provided as “Pending”

If a user does not have time to enter in all the required information in one sitting, they can save the **Service Provided** as **“Pending”** and come back to it later. To save it as **“Pending”**, click on the **Close** button and then **Yes** to save changes.



When a user wants to come back and complete the **Service Provided**, double click into the **“Pending”** **Service Provided** and click on the **Edit** button.



**It is important for Case Manager’s to return and complete Service Provided. Services Provided must be in “Completed” status to get included in reports.**

A user can view a list of all **“Pending”** **Services provided** by navigating to: **View > PAHR Activity > Services Provided Records Pending**.

## Marking Service Provided as “Completed”

To mark the **Service Provided** as “**Completed**” and save changes, click on the **Complete** button.

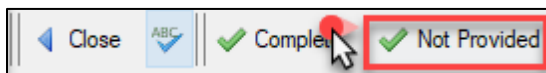


**Once a Service Provided is marked as “Completed” a user cannot edit the Service Provided. If need be, a user can mark a “Complete” Service Provided as “Deleted”**

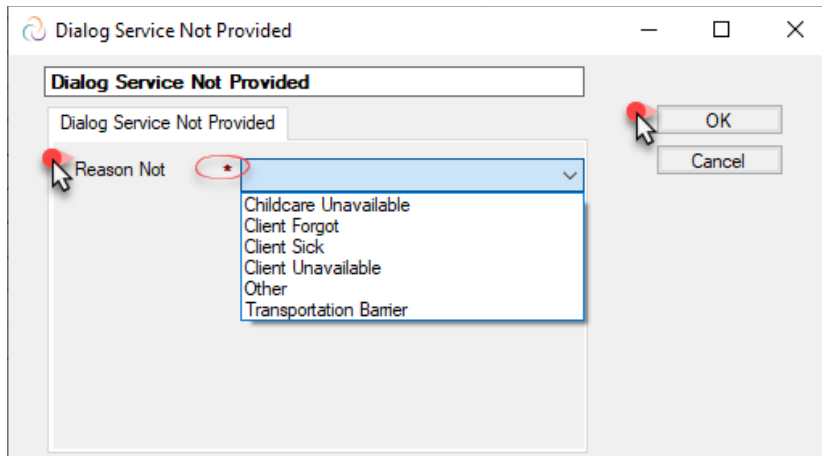
## Marking Service Provided as “Not Provided”

Marking the **Service Provided** as “**Not Provided**” will allow the user to document a service that was not actually delivered but was planned.

To mark the **Service Provided** as “**Not Provided**” and save changes, click the **Not Provided** button.



Select the reason you are marking the service as “**Not Provided**” and click **OK**.

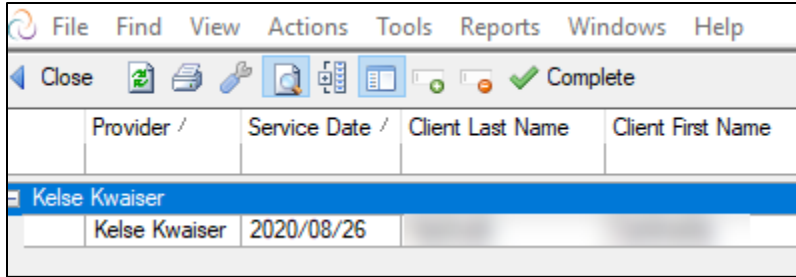


## Mass Completing Services Provided

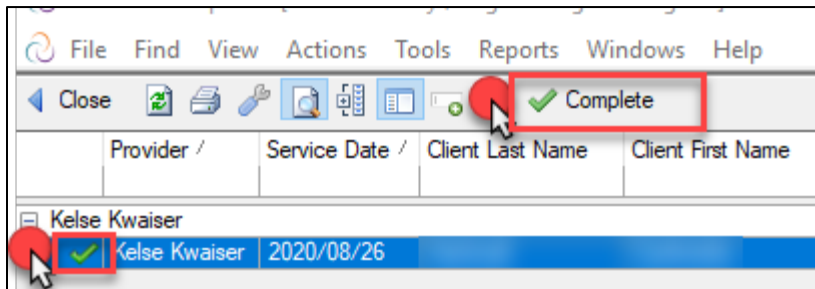
It is important to complete each **Service Provided** so they count on in reports. Instead of going into each client individually and completing their service provided record, a user can mass complete **Service Provided** records to save time.

Navigate to **View > PLWH Activity > Services Provided Pending** to see a view similar to this:

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Click to the left of the **Service Provided** records to mass select (select multiple) records. This action will place a green check mark next to each record the user wants to mark as **Completed** (see image below).



After mass selecting records to complete, click on the green **Complete** button. Provide will check through all selected records to confirm:

1. All the required fields (\*) are entered on every record selected for closure.
2. The client is indeed eligible for the service documented in the **Service Provided** form.

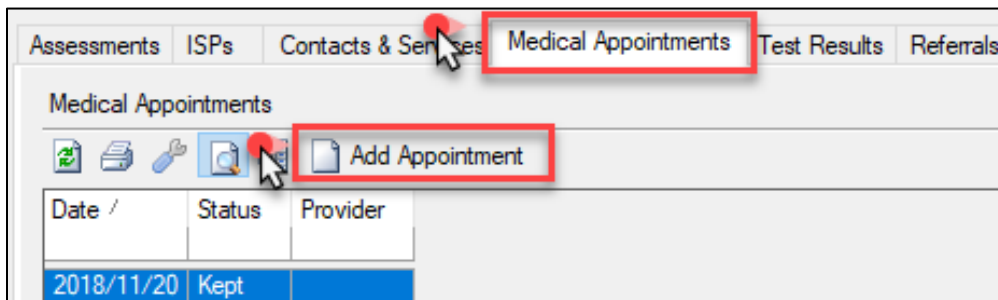
If the above checks out, the record will get completed and disappear from this view. If the above does not check out, the record will not be completed and remain in **“Pending”** status.

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## Appointment

This form is used to document scheduled, kept and missed appointments. It is useful to record appointments of all status (scheduled, kept, missed, etc.).

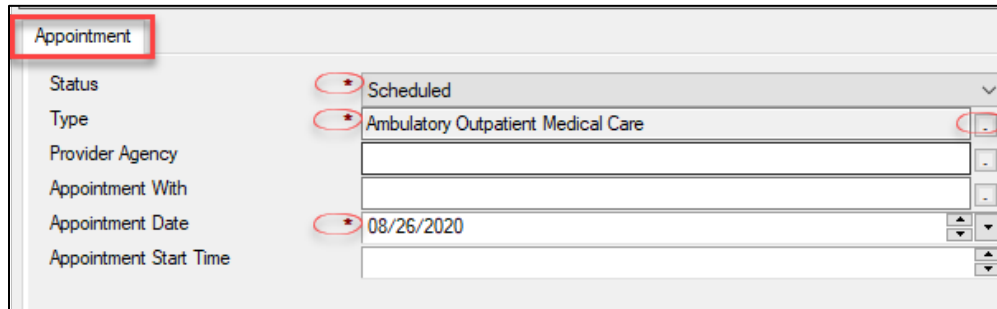
To create an Appointment, navigate from the **Client Profile > Case Management Summary View > Medical Appointments Tab >** click the **Add Appointment** form.





## Appendix C

Fill in the appropriate fields:



When finished, click on the **Close** button and then **Yes** to save changes. A user can come back into an appointment at any time and click on the **Edit** button to update the status of the appointment.

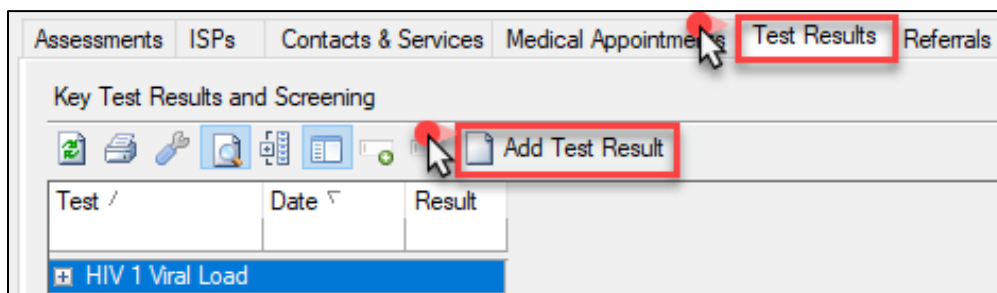
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## Test Result

This tab documents information related to specific medical tests a client has been given. At a minimum, each the following Tests need to be documented when a client has them performed:

- CD4 Count
- Viral Load
- Syphilis Screening
- Hepatitis B Screening
- Hepatitis C Screening
- PAP Smear
- Other STI Screenings

To create a **Test Result**, navigate from the **Client Profile > Case Management Summary View > Test Results Tab > click on the Add Test Result** button.



Fill in fields as appropriate.

## Appendix C

Test Result Attachments

Test Name

Test Date 08/26/2020

Test Result Status Final

Test Result Modifier =

Test Facility

Test Completed By

Entry Mode Manual

Test Result Comments

When finished, click on the **Close** button and then **Yes** to save changes.

## Referrals

To create an Internal or External **Referral**, navigate from the **Client Profile > Case Management Summary View > Referrals** Tab > click on the **Add Referral** button.

Assessments ISPs Contacts & Services Medical Appointments Test Results **Referrals**

Referrals

Add Referral

Status	Deleted	Date	Agency / Referred By	Referral Type	
Open	N	2020/08/13	Lifelong	Kelse Kwaiser	Other

Fill in the appropriate fields.

## Appendix C

- **Referring Person** – This will default to the user entering the referral, but a different person can be selected
- **Referral Type** – Select if this is an internal or external referral (details below)
- **Referred To** – Select the agency client is being referred to
- **Referred for Service Type** – Select the service type
- **Referred to Assignee** – If there is a referred to assignee, select it here
- **Referred for Service Description** – Enter the description of the referral service
- **Date Check Back** – Enter the date to check back on the referral.
- **Require Consent** – Verify Informed Consent via verbal or physical

<b>Internal Referrals</b>	<p>Sent to another agency <b>within the HIV Care Network, internal department or interagency group</b>. If the agency receiving the referral does not currently have access to the client record, <b>the referral submission will automatically generate an informed consent to the release the client</b> to the referred agency for 30 days.</p> <ul style="list-style-type: none"> <li>○ This gives the agency enough time to review, work, and potentially open a <b>Client Service Profile</b> associated with the referral.</li> </ul>
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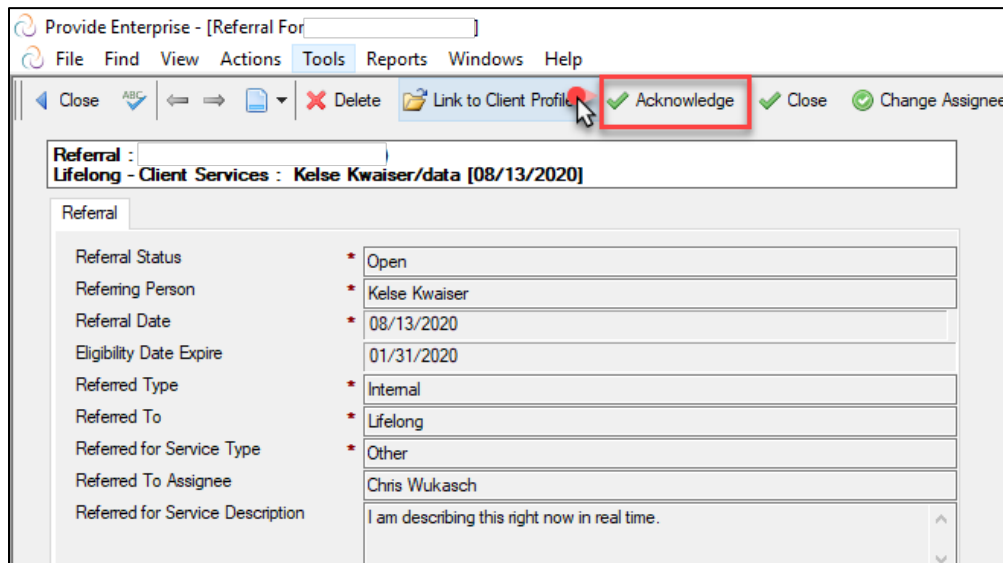
## Appendix C

	<ul style="list-style-type: none"><li>○ Opening a <b>Client Service profile</b> will keep the client chart open to the agency until the “HIV Care System” consent expires or until the agency closes their Client Service Profile.</li><li>○ The auto-generated Informed Consent is effective <b>five months prior</b> to the date the referral is submitted and lasting for <b>1 month after</b> submitted</li></ul>
<b>External Referrals</b>	Sent to agencies or providers <b>outside</b> the HIV Care Network.

When finished filling in the required (\*) fields, click on the **Submit** button to save changes and submit the referral.

### Referrals Acknowledgement

Referrals are “**Acknowledged**” by the receiving agency by clicking on the **Acknowledge** button. **Acknowledging** the referral will inform the referring provider that the referral has been received.



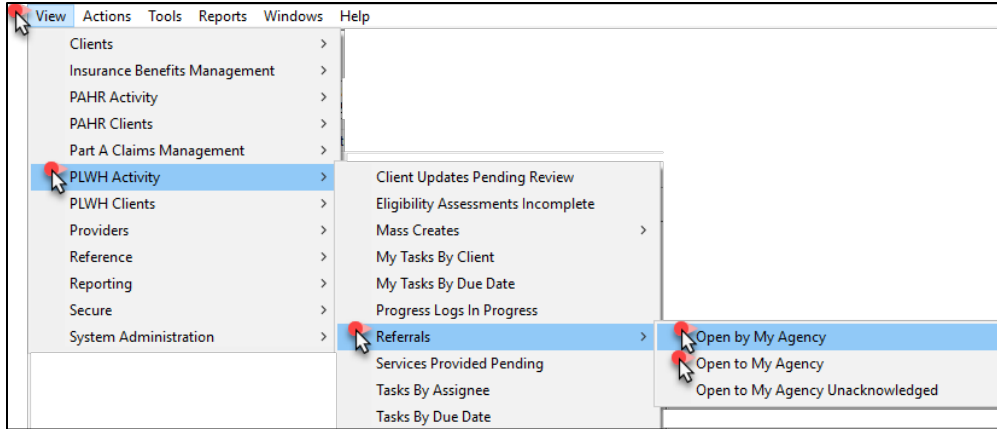
The screenshot shows the 'Provide Enterprise' software interface. The title bar reads 'Provide Enterprise - [Referral For]'. The menu bar includes 'File', 'Find', 'View', 'Actions', 'Tools', 'Reports', 'Windows', and 'Help'. The toolbar contains buttons for 'Close', 'Delete', 'Link to Client Profile', 'Acknowledge', 'Close', and 'Change Assignee'. The 'Acknowledge' button is highlighted with a red box. Below the toolbar, the 'Referral' form is displayed with the following fields:

Referral :	Lifelong - Client Services : Kelse Kwaiser/data [08/13/2020]
Referral Status	* Open
Referring Person	* Kelse Kwaiser
Referral Date	* 08/13/2020
Eligibility Date Expire	01/31/2020
Referred Type	* Internal
Referred To	* Lifelong
Referred for Service Type	* Other
Referred To Assignee	Chris Wukasch
Referred for Service Description	I am describing this right now in real time.

When a referral is **completed**, the agency receiving the referral will receive an email regarding the referral.

**Referrals** can be viewed by navigating to **View > PLWH Activity > Referrals views**.

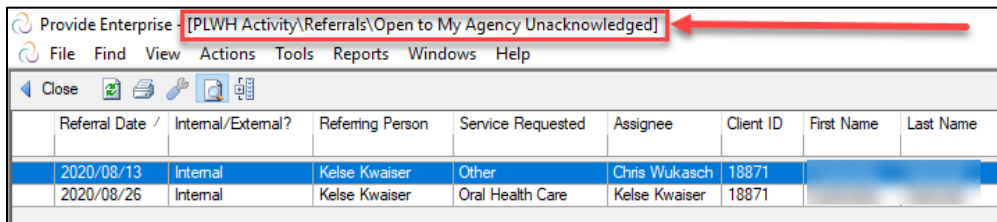
# Appendix C



To view referrals, select one of the three options:

- Open **by** My Agency
- Open **to** My Agency
- Open **to** My Agency **Unacknowledged**

Once in the desired view, double click any referral record to open the record.



**Once a referral is opened by the receiving agency, it cannot be edited by the sending agency.**