AMENDMENT NO. 1
TO STANDARD AGREEMENT
BETWEEN COUNTY OF MONTEREY AND
ACCESS SUPPORT NETWORK

THIS AMENDMENT is made to Agreement No. A-14271 for the provision of services to individuals and communities in Monterey County affected by HIV by and between **Access Support Network** (hereinafter referred to as CONTRACTOR) and The **County of Monterey**, a political subdivision of the State of California (hereinafter referred to as "County").

WHEREAS, on April 10, 2019, County and CONTRACTOR entered into Agreement in the amount of $298,235.00 for the term April 1, 2019 through March 31, 2024, for the provision of Human Immunodeficiency Virus (HIV) non-medical case management services to Ryan White Part B eligible clients; and

WHEREAS, County and CONTRACTOR wish to Amend the Agreement to increase the maximum contract liability by $178,614.

NOW THEREFORE, the County and CONTRACTOR hereby agree to amend the Agreement as follows:

1. **Section 2, "Payment Provisions", shall be amended by removing** "County shall pay the CONTRACTOR in accordance with the payment provisions set forth in Exhibit A, subject to the limitations set forth in this Agreement. The total amount payable by County to CONTRACTOR under this Agreement is not to exceed the sum of **$298,235.00, and replacing it with** "County shall pay the CONTRACTOR in accordance with the payment provisions set forth in Exhibit A, subject to the limitations set forth in this Agreement. The total amount payable by County to CONTRACTOR under this Agreement is not to exceed the sum of **$476,849.00.**

2. **Exhibit A is replaced with Exhibit A.1**. All references in the Agreement to Exhibit A shall be construed to refer to Exhibit A.1.

3. **Exhibit B is replaced with Exhibit B.1**. All references in the Agreement to Exhibit B shall be construed to refer to Exhibit B.1.

4. **Exhibit C is replaced with Exhibit C.1**. All references in the Agreement to Exhibit C shall be construed to refer to Exhibit C.1.

5. **Exhibit D is replaced with Exhibit D.1.** All references in the Agreement to Exhibit D shall be construed to refer to Exhibit D.1.

6. **Exhibit E is replaced with Exhibit E.1.** All references in the Agreement to Exhibit E shall be construed to refer to Exhibit E.1.

7. Except as provided herein, all remaining terms, conditions and provisions of Agreement are unchanged and unaffected by this Amendment No.1 and shall continue in full force and effect as set forth in the Agreement.

8. This Amendment No. 1 is effective April 26, 2021.

9. A copy of this Amendment No. 1 shall be attached to the original Agreement executed by the County on April 10, 2019.

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IN WITNESS WHEREOF, the parties have executed this Amendment No. 1 on the day and year written below.

MONTEREY COUNTY

Contracts/Purchasing Officer

Dated:

Approved as to Fiscal Provisions:

DocuSigned by:
Gary Giboney
D3834BFEC1D8449...
Deputy Auditor/Controller

Chief Deputy Auditor-Controller

Dated: 5/14/2021 | 10:25 AM PDT

Approved as to Liability Provisions:

Risk Management

Dated:

Approved as to Form:

DocuSigned by:
Marina Pantchenko
65EE9F1502BD412...
Deputy County Counsel

Deputy Deputy County Counsel

Dated: 5/12/2021 | 4:42 PM PDT

Director of Health

Dated:

CONTRACTOR

DocuSigned by:
By: Lisa M. Dean
E2010A6A72A4A1...
Signature of Chair, President, or Vice-President

Lisa M. Dean President

Printed Name and Title

Dated: 4/28/2021 | 6:10 AM PDT

DocuSigned by:
By: Ron Pigeon
E9AC1ACEA025444...
(Signature of Secretary, Asst. Secretary, CFO, Treasurer or Asst. Treasurer)*

Ron Pigeon Treasurer

Printed Name and Title

Dated: 5/10/2021 | 3:15 PM PDT

*INSTRUCTIONS: If CONTRACTOR is a corporation, including limited liability and non-profit corporations, the full legal name of the corporation shall be set forth above together with the signatures of two specified officers. If CONTRACTOR is a partnership, the name of the partnership shall be set forth above together with the signature of a partner who has authority to execute this Agreement on behalf of the partnership. If CONTRACTOR is contracting in an individual capacity, the individual shall set forth the name of the business, if any, and shall personally sign the Agreement.

RYAN WHITE PART B BUDGET & OPERATIONS GUIDANCE

HIV Care Program
&
Minority AIDS Initiative

(Funding Year 2013 – 2014)

Table of Contents

INTRODUCTION

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) is pleased to provide the Ryan White (RW) Part B Program Guidance for the HIV Care Program (HCP) and the Minority AIDS Program (MAI), Funding Year 2013-2014. Due to the realignment of contracts from the State Fiscal Year to the Federal Funding Year (FFY), this guidance is for July 1, 2013 through March 31, 2014 (nine months). OA will complete new three year term contracts in FFY 2014 for April 1, 2014 through March 31, 2017.

As the State grantee for RW Part B, OA allocates those funds for the administration of HCP and MAI through Cooperative Agreements with local health jurisdictions (LHJs) and community based organizations (CBOs) for the provision of medical and support services to persons living with HIV/AIDS (PLWH/A). For Health Resources and Services Administration (HRSA) policy requirements and legislative updates refer to HRSA's website at http://hab.hrsa.gov/manageyourgrant/policiesletters.html. Federal laws prohibit the use of federal funds to attempt to influence, directly or indirectly, any change in laws, regulations or governmental rule at the federal, state or local level.

This Guidance is designed to provide Contractors and Service Providers with the technical assistance needed to ensure efficient administration of invoices, reports, budgets, and contract monitoring for HCP and MAI. When read online, this document provides hyperlinks to additional resource available on the Internet.

If you require further clarification or technical assistance, please contact your RW Part B Advisor. Contact information can be found on the OA website at http://www.cdph.ca.gov/programs/aids/Documents/11MAD3cCareAdvisors.pdf

SERVICE CATEGORIES

HCP Allowable Services

The HIV care services to be provided under HCP are consistent with HRSA-defined service categories. HRSA Core Medical and Support Service category definitions in this section can also be found in the HRSA Program Monitoring Standards (PMS).
http://cdphinternet/programs/aids/Documents/HCPPtBProgramMonitoring.pdf

Additional guidance for RW Part B services that can be used to support Affordable Care Act (ACA) Outreach, Benefits Counseling, and Enrollment activities can be found at http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.

Tier I – Core Medical Services

RW Part B prioritizes *Outpatient/Ambulatory Medical Care (OAMC)* as a Tier I service. If OAMC is not budgeted through Part B funding, Contractors must provide a written justification to explain how OAMC is being addressed within their LHJ. There are additional HRSA Core Medical Services allowable in Tier I, contained in the list below. Definitions of all allowable services are also included in this guidance.

- *AIDS Drug Assistance Program (ADAP)*
- *Local AIDS Pharmaceutical Assistance Program (LAPAP)*
- *Oral Health Services*
- *Early Intervention Services (EIS)*
- *Health Insurance Premium and Cost-sharing Assistance*
- *Home Health Care Services*
- *Home and Community-based Health Services*
- *Hospice Care*
- *Mental Health Services*
- *Medical Nutrition Therapy*
- *Medical Case Management Services*
- *Substance Abuse Treatment Services-Outpatient*

Tier II – Support Services

Tier II services support access to Tier I care, maintenance in Tier I care, and reduce the risk of treatment failure and/or HIV transmission. To provide the greatest flexibility to local providers, the following list of HRSA service categories included in Tier II of RW Part B is extensive and varied.

- *Case Management (non-medical)*
- *Child Care Services*
- *Emergency Financial Assistance*
- *Food Bank/Home-Delivered Meals*
- *Health Education/Risk Reduction*
- *Housing Services*
- *Legal Services*
- *Linguistic Services*
- *Medical Transportation Services*
- *Outreach Services*
- *Psychosocial Support Services*
- *Referral - Health Care/Supportive Services*
- *Rehabilitation Services*
- *Respite Care*
- *Substance Abuse Treatment Services (residential)*
- *Treatment Adherence Counseling*

HRSA Service Categories Tier I (Core Medical Services) and Tier II (Support Services) are available on OA's website, under *'Resources for Care Providers'*.
http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx.

TIER I – CORE MEDICAL SERVICES

Outpatient / Ambulatory Medical Care (Health Services)		The provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Allowable services include: • Diagnostic testing • Early intervention and risk assessment • Preventive care and screening • Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions • Prescribing and managing of medication therapy • Education and counseling on health issues • Well-baby care • Continuing care and management of chronic conditions • Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services). Note: As part of OAMC, may include the provision of laboratory tests integral to the treatment of HIV infection and related complications.
ADAP		Funding allocated to a State-supported ADAP that provides an approved formulary of medications to HIV-infected individuals for the treatment of HIV disease or the prevention of opportunistic infections, based on income guidelines.
Local AIDS Pharmaceutical Assistance Program (LPAP)		Provision of HIV/AIDS medications using a drug distribution system that has: • A client enrollment and eligibility process • Uniform benefits for all enrolled clients throughout the Consortium region • A drug formulary approved by the local advisory committee/board • A recordkeeping system for distributed medications • A drug distribution system • A system for drug therapy management. LPAP does not dispense medications as: • A result or component of a primary medical visit • A single occurrence of short duration (an emergency)

		• Vouchers to clients on an emergency basis. LPAP is a program: • Consistent with the most current HIV/AIDS Treatment Guidelines • Coordinated with the State's Part B ADAP • Implemented in accordance with requirements of the 340B Drug Pricing Program. Note: LPAPs are similar to ADAPs in that they provide medications for the treatment of HIV disease. However, LPAPs are not paid for with Part B funds "earmarked" for ADAP.
Oral Health Care		Includes diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals.
EIS		Includes identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care. Part B funds can only be used for HIV testing, provided all four components above are present, and only as necessary to supplement, not supplant, existing funding. Note: To support ACA, EIS referrals and linkages to care may include enrollment in Medicaid, Medicare, private insurance plans through the health insurance Marketplaces/Exchanges and benefits counseling. Services are generally provided to clients who are new to care. http://hab.hrsa.gov/affordablecareact/outreachenrollment.html
Health Insurance Premium and Cost Sharing Assistance		Provides a cost-effective alternative to ADAP by: • Purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications • Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection) and deductibles on behalf of the client • Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs.

		Important: Contractors should refer to the HIV/AIDS Bureau (HAB) Policy Notice-07-05, "The Use of RW HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance." http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html
Home Health Care Services		Services provided in the patient's home by licensed health care workers such as nurses; services exclude personal care and to include: • The administration of intravenous and aerosolized treatment • Parental feeding • Diagnostic testing • Other medical therapies.
Home and Community-Based Health Services		Skilled health services furnished in the home of an HIV-infected individual, based on a written plan of care prepared by a case management team that includes appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities. *Note:* Inpatient hospitals services, nursing home, and other long-term care facilities are not home- and community-based services.
Hospice Care		Provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Allowable services: • Room • Board • Nursing care • Mental health counseling • Physician services • Palliative therapeutics.
Mental Health Services		Include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the

		State to provide such services, typically including, but not limited to, psychiatrists, psychologists, and licensed clinical social workers.
Medical Nutrition Therapy		Services including nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed registered dietitian.
Medical Case Management Services **(Including Treatment Adherence)**		Ensures timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following: • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary. Service components that may include: • A range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services) • Coordination and follow up of medical treatments • Ongoing assessment of the client's and other key family members' needs and personal support systems • Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments • Client-specific advocacy and/or review of utilization of services. *Note*: Medical case management is provided by dedicated professionals with nursing degrees, masters in social work, health care staff and, in some cases, no degree but with appropriate life experience. as stated in HRSA Care Action, November 2008: http://hab.hrsa.gov/newspublications/careactionnewsletter/novem

		ber2008.pdf For allowable uses of this service category to support ACA, refer to http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.
Substance Abuse Treatment Services (outpatient)		Provided by or under the supervision of a physician or other qualified/licensed personnel; may include use of funds to expand HIV-specific capacity of programs if timely access to treatment and counseling is not otherwise available. Services limited to the following: • Pre-treatment/recovery readiness programs • Harm reduction • Mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse • Outpatient drug-free treatment and counseling • Opiate assisted therapy • Neuro-psychiatric pharmaceuticals • Relapse prevention • Limited acupuncture services with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exists. 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 • The signature of the individual providing the service and or the supervisor as applicable. *Note:* Includes limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever State certification or licensure exists. As stated in the HRSA Policy Notice 10-02. http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html

TIER II – SUPPORT SERVICES

Case Management (non-medical)		Services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services. May include: • Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible • All types of case management encounters and communications (face-to-face, telephone contact, other) • Transitional case management for incarcerated persons as they prepare to exit the correctional system. Note: Does not involve coordination and follow up of medical treatments. Note: Supports Transitional Case Management for incarcerated persons as they prepare to exit the correctional system. http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.
Child Care Services		For children of HIV-positive clients, provided intermittently, only while the client attends medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training sessions. May include use of funds to support: • A licensed or registered child care provider to deliver intermittent care • Informal child care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services). Such allocations to be limited and carefully monitored to assure: • Compliance with the prohibition on direct payments to eligible individuals • Assurance that liability issues for the funding source are carefully weighed and addressed through the use of liability release forms designed to protect the client, provider, and the Ryan White Program. May include Recreational and Social Activities for the child, if provided

		in a licensed or certified provider setting including drop-in centers in primary care or satellite facilities. (Excludes use of funds for off-premise social/ recreational activities.)
Emergency Financial Assistance (EFA)		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: • Short-term payments to agencies • Establishment of voucher programs. Direct cash payments to clients are not permitted. *Note:* It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of RW HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, use and periods of time. Continuous provision of an allowable service to a client should be reported in the applicable service category, as stated in the HAB Policy Notice 10-02. http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html
Food Bank/ Home-Delivered Meals		May include: • The provision of actual food items • Provision of hot meals • A voucher program to purchase food. May also include the provision of non-food items that are limited to: • Personal hygiene products • Household cleaning supplies • Water filtration/purification systems in communities where issues with water purity exist. Appropriate licensure/certification for food banks and home delivered meals where required under State or local regulations. No funds used for: • Permanent water filtration systems for water entering the house • Household appliances • Pet foods • Other non-essential products.

Health Education/ Risk Reduction		Services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. Includes: • Provision of information about available medical and psychosocial support services • Education on HIV transmission and how to reduce the risk of transmission • Counseling on how to improve their health status and reduce the risk of HIV transmission to others. Note: Syringe Exchange Programs are no longer RW federally funded. See letter dated March 29, 2012 at: http://www.cdc.gov/hiv/resources/guidelines/PDF/SEC523.pdf For allowable uses of this service category to support ACA, refer to http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.
Housing Services		Short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Use of funds for: • Housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services • Housing that does not provide direct medical or supportive services • Housing-related referral services that include assessment, search, placement, advocacy, and the fees associated with them. No use of funds for direct payments to recipients of services for rent or mortgages. Note: A 24-month cumulative cap on short-term and emergency housing assistance has been rescinded pending completion of a comprehensive review of HRSA/HAB housing policy. *Note:* Housing funds cannot be in the form of direct cash payments to recipients and cannot be used for mortgage payments. Permanent living situations are not funded under this service category, for permanent housing options refer to Housing Opportunity for People with HIV/AIDS. As stated in the HAB Policy Notice 11-01. http://hab.hrsa.gov/manageyourgrant/files/policy1101.pdf.pdf
Legal Services		Provided for an HIV-infected person to address legal matters directly necessitated by the individual's HIV status. May include such services as (but not limited to):

		• Preparation of Powers of Attorney and Living Wills • Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under RW. Permanency planning and for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding (1) the drafting of wills or delegating powers of attorney, (2) preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption. Excludes: • Criminal defense • Class-action suits unless related to access to services eligible for funding under the RW HIV/AIDS Program.
Linguistic Services		Includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of RW-eligible services.
Medical Transportation Services		Enables an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens. May be provided through: • Contracts with providers of transportation services • Voucher or token systems • Use of volunteer drivers(through programs with insurance and other liability issues specifically addressed) Purchase or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle.
Outreach Services		Identify individuals who do not know their HIV Status and/or individuals who know their status and are not in care and help them to learn their status and enter care. Outreach programs must be: • Planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort • Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection

		• Targeted to communities or local establishments that are frequented by individuals exhibiting high-risk behavior • Conducted at times and in places where there is a high probability that individuals with HIV infection will be reached • Designed to provide quantified program reporting of activities and results to accommodate local evaluation of effectiveness. *Note:* Outreach services do not include HIV counseling and testing or HIV prevention education. Broad activities such as providing "leaflets at a subway stop" or "a poster at a bus shelter" or "tabling at a health fair" would not meet the intent of the law. As stated in HAB Policy Notice 12-01. http://hab.hrsa.gov/manageyourgrant/pinspals/outreachpolicy2012.pdf For allowable uses of this service category to support ACA, refer to http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.
Psychosocial Services		May include: • Support and counseling activities • Child abuse and neglect counseling • HIV support groups • Pastoral care/counseling • Caregiver support • Bereavement counseling • Nutrition counseling provided by a non-registered dietitian. Refer to PMS, page 37. http://cdphinternet/programs/aids/Documents/HCPPtBProgramMonitoring.pdf Note: Pastoral care / counseling are services that are: • Provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider, such as a home care or hospice provider). • Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available. • Available to all individuals eligible to receive RW services, regardless of their religious denominational affiliation. http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html

Referral for Health Care / Supportive Services		The act of directing a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services. May include benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services. Referrals may be made: • Within the Non-medical Case Management system by professional case managers • Informally through community health workers or support staff • As part of an outreach program For allowable uses of this service category to support ACA, refer to http://hab.hrsa.gov/affordablecareact/outreachenrollment.html.
Rehabilitation Services		Services intended to improve or maintain a client's quality of life and optimal capacity for self-care, provided by a licensed or authorized professional in an outpatient setting in accordance with an individualized plan of care. May include: • Physical and occupational therapy • Speech pathology services • Low-vision training.
Respite Care		Includes non-medical assistance for an HIV-infected client, provided in community or home-based settings and designed to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV/AIDS. Note: Funds may be used to support informal respite care provided issues of liability are addressed, payment made is reimbursement for actual costs, and no cash payments are made to clients or primary caregivers.

Substance Abuse Treatment Services (residential)		Addresses substance abuse problems (including alcohol and /or legal and illegal drugs) in a short-term residential health service setting. Requirements: • Services to be provided by or under the supervision of a physician or other qualified personnel with appropriate and valid licensure and certification by the State in which the services are provided • Services to be provided in accordance with a treatment plan • Detoxification to be provided in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of a hospital) • Limited acupuncture services permitted with a written referral from the client's primary health care provider, provided by certified or licensed practitioners wherever State certification or licensure exits. *Note:* Funds may not be used for inpatient detoxification in a hospital setting. Substance Abuse Services include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider, and the service is provided by a certified or licensed practitioner and/or program, wherever the State certification or licensure exists. As stated in HAB Policy Notice 10-02. http://hab.hrsa.gov/manageyourgrant/pinspals/eligible1002.html
Treatment Adherence Counseling		The provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments, provided by non-medical personnel outside of the Medical Case Management and clinical setting.

HRSA Service Categories Tier I (Core Medical Services) and Tier II (Support Services) are available on OA's website, under 'Resources for Care Providers', located at http://www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx.

MAI Allowable Services

The overall goal of the RW Part B MAI program is to improve minority access to HIV/AIDS medications to treat HIV/AIDS and prevent opportunistic infection through the Part B ADAP and as appropriate to other programs providing prescription drug coverage. http://hab.hrsa.gov/affordablecareact/outreachenrollment.html. Allowable service categories under the RW Part B MAI program are Outreach and Treatment Education.

Outreach

Outreach services should be conducted in times and in places where there is a high probability that persons of color and racial minorities with HIV infection will be reached. For the purpose of MAI funding, outreach is defined as those activities typically performed by an outreach worker that results in:

- *Identifying HIV-infected persons of color who have never been in care or who have been lost to HIV medical care;*
- *Removing barriers that have prevented access to HIV medical care; and*
- *Linking HIV-infected individuals to eligibility workers that can get these individuals into care and enrolled in ADAP.*

MAI outreach services do not include routine HIV counseling and testing or HIV prevention education. These services may be provided on a case-by-case basis for a specific MAI client only when the service is necessary to remove a barrier to care for that client.

Activities such as, providing leaflets at an outside public place or a poster at a bus shelter or tabling at a health fair is not allowable under this service category. Early Identification of Individuals with HIV/AIDS (EIIHA) activities can be reported under this service category and/or EIS.

Treatment Education

For the purpose of MAI funding, Treatment Education is defined as providing health education, treatment adherence, and risk reduction information to HIV-infected persons of color. Information includes educating clients living with HIV about local eligibility workers (ADAP) and the importance of treatment adherence.

QUARTERLY NARRATIVE REPORTS

The Quarterly Narrative Report is required and provides an opportunity for Contractors to describe general accomplishments, to raise issues or concerns, and to request any technical assistance and/or training needs and the current form is on the OA website. http://cdphinternet/programs/aids/Pages/HCPForms.aspx

Quarterly Narrative Report due dates, as well as Quarterly Invoicing due dates are provided on the following table:

REPORT PERIODS	***DUE DATES***
JULY 1 – SEPTEMBER 30	NOVEMBER 15
OCTOBER 1 – DECEMBER 31	FEBRUARY 15
JANUARY 1 – MARCH 31	MAY 15

If the due date falls on a weekend, the Quarterly Narrative Reports are due the following business day.

BUDGETS

The OA uses the HRSA approved State Direct Services Category to allocate Part B funds to LHJs and CBOs. This allows the contractor the maximum flexibility when prioritizing Part B funds.

Budget forms for FFY 2013-14 services must be submitted as instructed in this guidance. Contractors are required to maintain accurate, detailed records of services and expenditures associated with HCP and MAI funds. It may be necessary to estimate the number of clients who are eligible for other programs in order to more accurately estimate budgeted funds for each service category.

Finalized budgets must be submitted electronically to the assigned RW Part B Advisor. Contractors should contact their assigned RW Part B Advisor for assistance and questions regarding this guidance.

Note:

- *MAI allocations, if applicable, are **not** to be combined in the HCP budget and are to be submitted using separate MAI budget forms.*
- *Contractors and Service Providers must consider budgeting for service categories that represent unmet need in their LHJ and assure that Part B funds are used as payer of last resort*

ALLOCATIONS

The Single Allocation Model is an administratively streamlined model for providing care and support funds to local providers. Based on the specific needs, appropriateness, and capacity at the county level, OA contracts with either the county health department or a CBO as the single Contractor in a given LHJ.

BUDGET INSTRUCTIONS AND DEFINITIONS

Affordable Care Act (ACA):
Contractors should consider the impact of the ACA on program services for FFY 2013-14 when developing budgets. Services funded in the past may not need to be funded at the same level as some RW clients will transition to other programs. OA expects Contractors to assess any savings in Outpatient Ambulatory Medical Services and redirect funds to other HRSA allowable Tier I or Tier II categories of services that represent highest need. Please remember budgets for FFY 2013-14 contracts are for nine months as we transition from the State Fiscal Year.

Please adhere to the following definitions when completing the Contractor and Service Provider Budget Documents.

Administrative Costs *(Please refer to the Administrative Costs Allowances Diagram for additional information.)*	The sum of Administrative Personnel, Operating Capital, and Indirect Costs. Contractor and Service Providers cannot exceed **10 percent** of their total allocation without justification and management approval from HCP. **Note:** Please be sure to contact your OA Care Operations Advisor if you would like to request more than 10 percent allocation to Administrative Costs **Note:** A receptionist that assists clients and directs phone inquiries for single or multiple programs is Administrative Personnel and is not to be charged as a service category cost. A receptionist is an Administrative function.
Personnel	Contractor and Service Providers total salaries, wages, benefits, and travel paid to staff providing administrative support and costs associated with staff providing direct client services.

Non-Personnel	Service Providers allowable expenses associated with providing direct client care (supplies, materials, medical equipment, nutritional supplements, lab tests, food, and transportation vouchers, etc.) **Note:** For all non-personnel costs budgeted, include a detailed justification with an itemized list of items included.
Operating Expenses	Contractor and Service Providers Operating Expenses for program operations may include non-personnel costs, office supplies, postage, facilities, telephone, Internet connection, encryption software, minor equipment (unit cost under $5,000), and travel, etc. **Note:** Equipment approved and purchased by OA must be tagged, inventoried annually, and reported annually to OA.
Capital Expenses	Includes computers, printers, and other types of equipment, with a unit cost greater than $5,000. Capital Expenses must be approved by HCP prior to purchase. **Note:** If requesting Capital Expenses, a written justification must be provided that: • Lists the equipment that is being requested; • Explains who will use the equipment and for what purpose; • Explains why it is necessary to purchase the equipment; • Includes a purchase versus lease analysis for “large dollar” items; and • Equipment approved and purchased by OA must be tagged, inventoried annually, and reported annually to OA.

Other Costs	Unique program costs and costs not applicable to any other line item. Other costs include: • Contractor (as the Service Provider) non-personnel client services (i.e., food and transportation vouchers, labs, etc.); and • Needs Assessment costs and all subcontracted client Service Provider costs.
Indirect Expenses	Typical indirect expenses are costs that cannot be assigned to one program. Often this category is used when a Contractor has multiple programs and divides the rent, utilities, janitorial services, payroll accounting, etc., either equally between programs or based on the percentage of time spent on a program. **Note:** Indirect Expenses are limited to **15 percent** of Personnel Expenses. Contractors cannot exceed 15 percent of their total Administrative Personnel and Client Service Providers cannot exceed 15 percent of their personnel.

Below are instructions on how to complete budget documents:

1. Work closely with your RW Part B Advisor to ensure the submitted budget is accurate and will require minimal changes when the final budget is submitted;
2. Complete all budget forms, including filling out all check boxes;
3. Include all contact information including billing address, if it differs from the mailing address;
4. Include the Contractor and Provider DUNS # where indicated;
5. Round all figures to the nearest whole dollar;
6. Provide description/explanation of all **non-personnel** funds to show the activities those funds will be used for;
7. Provide contracted and subcontracted service provider agency locations/addresses where client charts are case managed and screened for eligibility;
8. Submit budget forms to your RW Part B Advisor on or before each specified due date; and
9. Refer to the instructions below to complete the budget documents identified in the corresponding tab on the Excel spreadsheet.

Document Checklist: The Document Checklist (and MAI Document Checklist, if applicable) must be completed by the Contractor to certify that all required budget documents have been accurately completed and submitted in a timely manner as per OA's RW Part B deadlines.

Contractor Agency Location List (when Contractor is also the Service Provider): List all Contractor Agency locations where Contractor provides direct services. If Contractor is a Fiscal Agent only and subcontracts out direct services, indicate Fiscal Agent Not Applicable below. This is required for scheduling annual site visits and completing the annual HRSA RW Services Report (RSR). Identify all Administrative Agency Offices where client charts reside for case management and eligibility screening documentation is included.

Service Provider Agency Location List (Include sub-subcontractors when initial subcontracted Service Provider is a Fiscal Intermediary only): List all subcontracted Service Provider Agency Locations. If Service Provider is a fiscal intermediary only, list all sub-subcontracted Service Provider Agency and locations. This information is required for scheduling annual site visits and completing the annual HRSA RSR. Identify all Administrative Agency Offices where client charts reside for case management and eligibility screening documentation is included.

Contractor Contact Information: The Contractor Contact Information (and MAI Contractor Contact Information) form provides RW Part B program with the Contractor's staff names responsible for daily programmatic and fiscal operations. Notify your assigned RW Part B Advisor of any changes to the Contractor's contact information.

Five Line Item Budget Definitions

All Contractors are required to submit a five line item budget for the duration of the contract term with the understanding that individual line items (budget details) are submitted annually.

Note: Please be sure to use the forms provided with this guidance and note the changes to the Five Line Item Budget Form in the applicable items below.

Personnel Expenses (Salary) Includes LHJ or CBO staff costs, and are the sum of Contractor -Total Administrative Personnel/Salary (Form A), and Contractor's Total Personnel Expenses (Form E)/Salary, if the Contractor is also, listed as a Service Provider. *New Change:* Salaries and Benefits cannot be combined together and must be documented separately as a subset of Personnel.

Note: Please ensure that the **Contractor's Administrative Costs** and the Total Contractor Administrative Budget on Form A under Contractor Administrative Budget Summary, does **not exceed ten percent** of the total administrative allocation.

Operating Expenses: Operating expenses are the Contractor's costs and are the sum of operating costs on Form A and operating costs on Contractor's Form D, if the Contractor is also a Service Provider.

Capital Expenses: Are the Contractor's costs and the sum of capital expenses (Form A) and capital expenses on Contractor's (Form D), if the Contractor is also listed as a Service Provider.

Other Costs: Includes the sum of the total Contractor's needs assessment budget on Form C, any non-personnel client services (e.g., transportation vouchers) on Contractor's Form D, including the total of subcontracted Client Service Provider budgets on Form D.

Note: *New Change:* Contractor Needs Assessments, Non-Personnel client services from Form D, and each subcontracted Client Service Provider budget amounts must be listed as a subset of *Other Costs* to support the total sum of *Other Costs.*

Indirect Costs: Are the Contractor's costs and the sum of Indirect Costs on Form A, and indirect costs on Contractor's Form D, if the Contractor is also listed as a Service Provider.

Budget Detail Forms Definitions

Budget Overview Form: Indicates how the total allocation of funds is distributed between the Contractor and Client Service Provider(s).

1. Enter the budget amounts for Client Service Provider Costs (whether provided by a Contractor and/or subcontracted agency).
2. The Contractor Costs and Needs Assessment Costs fields on the form will automatically update when Forms A and C are completed.
3. The Budget Overview Form must equal the total allocation

Form A - Contractor Administrative Budget Summary: Identifies the Contractor and itemizes expenses. Complete Form A as follows:

1. Complete the Total Administrative Personnel, Operating Expenses, and Indirect Costs;
2. Itemize any Operating Expenses or Indirect Costs;
3. Include a written justification, if using the Capital Expenses line item;
4. Ensure Indirect Costs do not exceed fifteen percent of total Administrative Personnel Expenses;
5. The Total Administrative Personnel Expenses identified on Form A is equal to the sum of the Total Personnel Expenses on Form B; and
6. Ensure total Contractor administrative costs do not exceed ten percent of the total allocation. The ten percent calculation for the Contractors Administrative Budget on Form A will be calculated once the five line item budget form has been completed.

Form B - Contractor Administrative Personnel Detail: Contractor Administrative Personnel Detail identifies the personnel providing administrative services including staff salaries. Complete Form B as follows:

1. Complete Contractor information;
2. Describe the duties of each employee and including justification of job-required travel (e.g., training);
3. Complete either the “Annual Salary” or “Hourly Salary” box and the “Salary paid by this contract” box for each employee;
4. If travel is required, enter the estimated travel expense;
5. Enter the Benefits, if any, for each employee;
6. Make additional copies of this form if there are more than four employees; and
7. The Total Administrative Personnel Costs identified on Form A is equal to the sum of the Total Personnel Expenses on Form B.
8. **Note:** The new highlighted total line on the bottom of the form separating Total Personnel in to Total Salary and Total Benefits.

Form C - Needs Assessment Detail (not required or applicable for MAI): Contractors are required to conduct a full needs assessment at least once during the nine-month contract period and is required as part of the Service Delivery Plan (SDP).

Note: Form C needs to be completed whether you are conducting the Needs Assessment directly or through a subcontracted agency.

Form C must include the following:

1. Describe the duties of the person conducting the Needs Assessment and include details about any travel associated with the Needs Assessment;
2. Ensure the total Needs Assessment budget does not exceed 5 percent of the total contract allocation;
3. Ensure the contract start date corresponds with the actual date the work begins on the Needs Assessment; and
4. Report the Needs Assessment costs under "Other Costs" on the five line item budget.

Note: A copy of the Needs Assessment must be sent to your RW Part B Advisor within forty-five days of completion. Contractors in Eligible Metropolitan Areas (EMA) or Transitional Grant Areas (TGA) can submit their Planning Council's Comprehensive Plan in lieu of the SDP (and Needs Assessment). The use of RW Part B funds is prohibited for the Needs Assessment when a Comprehensive Plan is submitted.

Form D - Client Service Provider Budget Summary: Provides information regarding the estimated number of clients to be served, the costs of administrative and direct client services, and indirect and operating expenses.

Note: Form D is required for each Client Service Provider, whether services are subcontracted or provided by the Contractor.

Form D must include the following:

1. The Client Service Costs completed with the exact HRSA category as allowable for HCP Tier I Core Medical Services and Tier II Support Services (MAI service categories, if applicable). (Click the drop-down box under Services and select the appropriate category.);
2. Include the personnel and non-personnel amounts for each category (for example, Outpatient/Ambulatory Medical Care may have personnel costs as well as non-personnel costs such as labs;
3. A copy of the policy and tracking method if funding Emergency Financial Assistance;
4. The estimated number of unduplicated clients to be served; and
5. The Administrative Personnel Expense, Operating, Capital, and Indirect Expense categories as instructed in the Definitions for Budget Documents.
6. **Note:** *New column* RW Program Part B – Payer of Last Resort, please describe how part B funds are used as a payer of last resort for this

HRSA Service Category by identifying other funding sources paying for the same service. The explanation must also include the percent Part B funding represents or is being utilized as Payer of Last Resort. *(Ex: If funding OAMC using funds from Part A and B, the description may read funded by Part A and Part B of which Part B funding backfills ten percent of OAMC costs).*

Note: Written justifications, to be approved by RW Part B Advisor, must be provided for the following items:

1. Non-personnel amounts submitted to explain what those amounts are going to be used for;
2. Service Provider's administrative costs exceed ten percent of the Service Provider's allocation;
3. Capital Expense line item is greater than zero (see Definitions for Budget Documents); and
4. Client Service Provider was sole sourced.

Form E - Client Service Provider Personnel Detail: This form provides information on administrative staff and staff that provides services directly to clients. Form E is required for each Client Service Provider, whether services are subcontracted or provided by the Contractor.

Form E must include the following:

1. Describe the duties of each employee;
2. Include details about job-required travel (e.g., client-related travel, training, etc.);
3. Complete two position sections for any staff whose duties are split between Administrative and Direct Client Service and "yes" or "no" under "Is this an administrative position?";
4. Use State's per diem reimbursement rates to estimate travel expenses;
5. Provide "Annual Salary", the "Total FTE" the "Salary paid by this contract", along with "Travel" and "Benefits" (if applicable) for each employee;
6. Enter exact name of HRSA Client Service Category provided by employee (click on the drop-down box next to "HRSA Service Category" and select the appropriate service category or click on "N/A - Administrative Position" for administrative staff); and
7. Make additional copies of this form if there are more than four employees.

8. Note the new highlighted line on the bottom of the form separating Total Personnel in to Total Salary and Total Benefits.

Form F --Service Provider Subcontractor: This form provides information on subcontracted Service Providers who utilize subcontracts to fund other entities to provide RW Part B services. This form must be duplicated and completed for each entity.

Non-Personnel Information: Service Provider Non-Personnel funds provided on Form D and F need to be explained here. Provide an explanation to describe what is included in the Non-Personnel expenses that require RW Part B funds. List services, providers, and allocations in the new column should correspond with Form D.

EIIHA Strategy/Plan: All HCP Contractors are required to submit an EIIHA strategy/plan or written justification.

All EIIHA activities should be reported under EIS and/or Outreach service categories. If the services needed to implement an EIIHA strategy/plan are funded by another source other than HCP, list funding sources associated with each EIIHA activity. Contractors who are able to budget and demonstrate that they are providing EIIHA activities through other funding, such as RW Part A, Part C, and the Centers for Disease Control (CDC) Prevention, may not have to use HCP to budget for EIIHA.

All Contractors should consider the following regarding EIIHA:

- Satisfy EIIHA through CDC's Prevention funding;
- Satisfy EIIHA through HCP in either EIS and/or Outreach;
- Satisfy EIIHA through other RW funding sources such as, Part A, Part C, etc.
- Address how EIIHA activities are being met through HCP within the LHJ by providing an EIIHA strategy/plan; and
- Address why EIIHA activities are not a focus within the LHJ by providing a written justification.

Explanation for not Providing Outpatient/Ambulatory Care with HCP Funs: The explanation must include where clients in your service area are receiving their Outpatient/Ambulatory Care.

Additional Requirements for Contractors receiving RW Part A funds

For contractors that are funded by Part A and Part B and are budgeting for services that are covered by both Part A and B, the Part B budget for the dually funded service must

indicate the percent of funding that Part B represents. Specify the percentage of the award that is Part B and Part A on your submitted Budget Forms - Form D, in the new column named "RW Program Part B - Payer of Last Resort Assessment/Comments."

Make sure that all invoices accurately reflect Part B expenditures and OA receives only Part B invoices. If both Part A and B funds are used to fund the same service for the same patient population, you need to implement a formula to draw down both Part A and Part B funds at the same time. The percentage of funds that are expended by Part B should be based on the percentage of Part B funds allocated for the entire service category.

Note: OA recommends contractors funded by Part A and Part B to budget separate services, and only use Part B funding for services not covered by Part A. Additionally, Part B administrative funds should only be used to cover any additional administrative costs which are not covered by the Part A; administrative Part A and Part B funds need to be tracked and reported separately.

Line Item Shifts and Budget Revisions

Contractors should continuously assess their budgets and shift money based on expenditures and need. Line Item Shifts and Budget Revisions can occur quarterly to assist Contractors in moving funds to accommodate the service needs of their LHJs.

Line Item Shifts (five line budget): Contractors are allowed line item shifts up to **fifteen percent** if it does not increase or decrease the annual contract total amount. Additionally, Contractors are allowed to revise dollar amounts, personnel, service categories, and service provider information as needed. In order to make a line item shift and/or budget revision, the Contractors are required to submit required budget documents to their RW Part B Advisor.

Budget Revisions (service categories): Service Provider subcontracted dollar amounts are reported in the "Other Costs" line item and, therefore, are not considered line item changes. Service Providers that are subcontracted must notify the Contractor of any budget shifts or changes in services, allocations, and/or personnel. It is the responsibility of the Contractor to notify their assigned OA RW Part B Advisor, and provide a revised budget packet, before the budget revisions can be implemented.

Note:

- *The revised budget packet must include all previously approved Budget Forms and required changes should be in different color for easy identification, showing each line item that has been impacted, a revised Summary Tracking form, and a justification for the revision.*
- *Changes, additions, and/or deletions of Service Providers and/or of any Personnel must also be submitted as a budget revision to your assigned RW*

Part B Advisor. This information will be used to update the services for each provider's RW "contract" in the AIDS Regional Information and Evaluation System (ARIES).

- *ARIES contracts must mirror the most recent budgets so that providers collect and report their funded services on their annual RSR.*

INVOICE SUBMITTAL REQUIREMENTS

Contractors must submit invoices for reimbursement of expenses incurred on a monthly or quarterly basis. Invoices must be based on actual expenses incurred within the month/quarter specified, and the expenses claimed must be from the approved budget.

Signed electronic PDF copies of invoices are due to RW Fiscal Analyst, Ivo.Klemes@cdph.ca.gov, **forty-five days** following the end of each billing period. When submitting invoices to OA, contractors are required to include the HCP or MAI Summary Tracking Form which provides data required by HRSA for OA reporting.

Note: Information from the HCP Financial Report is now reported in HCP Summary Tracking. Therefore, separate Quarterly Financial Reports for HCP and MAI are no longer required.

COMPLIANCE PERFORMANCE MONITORING

The goal of contract monitoring is to ensure compliance with State and Federal programmatic and fiscal requirements. OA is committed to providing technical assistance to Contractors and Service Providers to ensure continued compliance to monitoring requirements.

In 2011, HRSA implemented National Monitoring Standards (NMS) for performance measures. The NMS is designed to help RW Part B Program meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness.

The requirements set forth have been consolidated into a single monitoring tool that provides direction and advice to HCP and MAI Contractors for monitoring both their own work and the performance of Service Providers. Contractors who subcontract out some or all services to other providers are required to monitor the performance of their subcontractors / service providers for compliance in accordance with this guidance and the NMS. Contractors are to use the OA monitoring tool when completing annual site visits of their subcontractors / service providers and have documented results available for the RW Part B Advisor during the annual Contractor site visit.

NATIONAL MONITORING STANDARDS (NMS)

Implementing HRSA's NMS is a process comprised of a set of systems that address all monitoring components of the HRSA standards including, but are not limited to:

a. *Fiscal Monitoring:* A system to assess the appropriate use of funds including the control, disbursement, use and reporting of allowable costs; and

b. *Program Monitoring:* A system to assess whether allowable services are provided to eligible clients according to service limits. Program monitoring may include reviewing program reports, conducting site visits, and reviewing client records or charts.

The NMS consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies, and guidance documents.

OA implementation process of the NMS includes a variety of contract monitoring methods to include audit reviews, desk audits, and site visits. Infrastructures around site visit preparations, chart reviews, and six-month re-certifications have been developed in accordance with the HRSA NMS. HCP and MAI Contractor/Service Provider

requirements set forth by HRSA are available on OA's website. http://www.cdph.ca.gov/programs/aids/Pages/HCPNatlMonitoringStds.aspx

Contractors are required to provide any needed assistance to the State in carrying out its monitoring activities, including, but not limited to making available all records, materials, data information, and appropriate staff to authorized State and/or Federal representatives.

On-going program monitoring will also be conducted by evaluating progress towards the objectives described in the scope of work (SOW). Additional information will be forthcoming regarding the requirements to submit SOW progress reports. For additional information on SOW, refer to Section 2.

MONITORING PROCESS

OA monitors HCP and MAI Contractor/Service Providers through a variety of methods. OA continuously reviews and monitors fiscal, programmatic, and administrative performance through Contractor and Service Provider budgets, invoices, narrative reports, fiscal reports, site visit activities, audit reports, SDPs, and needs assessments.

Note: Contractors who subcontract out any or all required services to other entities are responsible for monitoring their subcontractors, including site visits. Contractors must ensure they monitor for all components as outlined in the HRSA Program and Fiscal NMS found on the OA website at http://cdphinternet/programs/aids/Pages/HCPNatlMonitoringStds.aspx.

OA utilizes several data reports and tools generated from ARIES that assist in regular monitoring of Contractor and provider compliance and include:

1. Data Monitoring and Evaluation Report - Summarizes key data elements for the RW Part B clients the provider served during the FY. The selected data elements include: proof of HIV diagnosis, insurance status, federal poverty level, "share" status and consent, estimated and actual number of clients served by service category. The report identifies areas that need improvement.

2. RW Part B Chart Selection Report - A tool to provide a random list of clients who received at least one RW Part B service in the FY being monitored. Contractors are required to generate the list from ARIES, and have the charts available, in preparation for annual site visits which will be used by RW Part B Advisor (or MAI Health Specialist) when conducting chart reviews.

3. Client Chart Review – RW Part B Advisors (or MAI Health Specialists) review the charts for required documentation and verification of eligibility that includes: client name, intake information, proof of HIV status, selected forms (e.g., ARIES Share Consent form, client rights, grievance procedures, etc.), financial status (e.g., proof of income, employment, payer of last resort, etc.). Time required to review each chart depends on the chart complexity and organization.

Site Visit Overview

The purpose of the on-site visit is to verify contractual compliance with the HRSA program and fiscal NMS and to provide needed technical assistance. Site visits and other monitoring activities will occur during the current grant year between April 1 and March 31. The RW Part B Advisor will contact each Contractor to schedule a site visit for monitoring of prior Funding Year records and performance. During the site visit, the RW Part B Advisor reviews fiscal and programmatic information to ensure compliance with all applicable State and Federal requirements. HCP and MAI Contractors/Service Providers are required to have fiscal policies and procedures that address the following:

- *Tracking and monitoring of services ordered, billed, and delivered;*
- *Tracking of Administrative costs to ensure ten percent cap is not exceeded;*
- *Identification of expenditures by HRSA's defined service categories;*
- *Tracking of food and transportation expenditures by client, date, and amount;*
- *Determining if any subcontractor, whether and individual or agency, has been disbarred or ineligible prior to subcontracting.*
- *HCP and MAI Contractor/Service Providers are required to maintain adequate documentation to support the appropriateness of expenditures incurred under the terms of the contract; and*
- *Submit timely invoices with appropriate documentation for reimbursement.*

Site Visit Scheduling Process

OA utilizes the following process to schedule site visits. HCP and MAI Contractors and Service Providers are required to work with OA to manage and adhere to the process below as much as possible. OA is responsible to ensure all HCP and MAI Contractors receive a site visit annually and will provide technical assistance to Contractors to

ensure the monitoring of Service Providers within their LHJ is compliant with the HRSA NMS.

The site visit process timeline is outlined below:

INITIAL NOTIFICATION	60 days
ENTRANCE LETTER	45 days
CONTRACT REVIEW (OA in-house)	30 days
SITE VISIT MONITORING (on-site)	SCHEDULE DATE
REPORT COMPLETE or CAP REQUESTED	30 days
CAP REPORT DUE	30 days
CAP APPROVAL/FILE UPDATE	60 days

Site Visit Corrective Action Plans (CAP)

RW Part B Advisors require Contractors to develop and implement a CAP to address deficiencies found during the site visit monitoring and chart review process. The CAP is due 30 days after receiving a completed site monitoring report from OA. RW Part B Advisors will follow up to ensure that the CAP has been implemented.

HCP AND MAI ANNUAL AUDITS

HCP and MAI Contractors and Service Providers are required to be audited annually by an independent auditor as part of an organization wide audit and receive an A-133 Audit Report or an Audited Financial Statement which applies to the following:

- *Financial operations are properly conducted;*
- *Financial reports are fairly presented;*
- *The HCP and MAI Contractor/Service Provider(s) complied with all applicable laws, regulations, and administrative requirements that affect the expenditure of RW Part B funds.*

Local government audits are submitted directly to the State Controller's Office. Because our federal grantee may request electronic copies of all the audits at any time, the RW Part B Fiscal Analyst (FA) collects electronic copies of all annual audits to keep on record.

OA contracts are audited annually by the State Audits and Investigations (A&I) Branch of the California Department of Health Care Services. A&I performs general or targeted financial and/or programmatic reviews of all OA Contracts and Service Providers at least once during the contract term. New Contractors are initially audited after completing the first contract year.

Note: The monitoring and CAP processes above help to ensure local HCP and MAI providers comply with the contract and SOW to minimize potential fiscal findings and recovery reports by A&I.

A-133 and Independent Financial Statement Audits

The table below provides an overview of the A-133 and Financial Statement Requirements:

Item	A-133 Audits	Financial Statement
Requirements	Each private non-profit HCP/MAI contractor/subcontractor that expends over $500,000 annually in total federal awards is required to complete an A-133 Single Annual audit. The HCP/MAI Contractor/Service Provider must obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133. The A-133 is an independent audit that determines if funds are expended for allowable costs, expenditures are in accordance with program objectives, and internal controls are in place.	The Financial Statement audit is an independent annual financial audit conducted for private non-profit HCP/MAI contractors/subcontractor. As defined by Health and Safety Code Sections 38040 and 38041, if a private non-profit local agency under a State of California direct service contract, received less than $500,000 in total federal monies, the HCP/MAI provider is required to complete only the Financial Statement audit, rather than an A-133 Single Annual audit. The HCP/MAI Contractor must obtain an annual (biennial if less than $25,000 in federal funds), organization wide, financial and compliance audit.
Due Date and Submission	Electronic PDF copy of the A-133 audit report is due to HCP/MAI FA within 30 days after the completion of the audit but no later than the end of the ninth month following the end of the HCP/MAI Contractor/Service Provider's fiscal year.	Electronic PDF copy of the Financial Statement audit must be e-mailed to HCPB/MAI FA within 30 days of completion of the audit but no later than five (5) months and 15 days of the HCP and MAI Contractor/Service Provider's fiscal year end.
Audit Contents	The A-133 Single Audit report submitted by the HCP/MAI agency should include these minimum components**:** • Independent auditor's opinion stating that the audit was conducted in accordance with the provisions of OMB Circular A-133 and in accordance with Generally Accepted	The Financial Statement audit, at a minimum, must include: • Independent auditor's opinion stating that the audit was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS). • Audited Financial Statements. • Note accompanying the Financial Statements.

Item	A-133 Audits	Financial Statement
	Government Auditing Standards (GAGAS). • Audited financial statements. • Schedule of expenditures of federal awards and opinion thereon. • Report regarding the internal controls over compliance with laws and regulations and provisions of contracts or agreements that could have direct and material effect on the federal program. • Schedule of findings and questioned costs. • Auditee's corrective action plans (if any). • Summary schedule for prior audit findings which includes planned and completed corrective actions (if any).	• Separate report in accordance with GAGAS.
Tracking and Review	The HCP/MAI FA tracks all audits received and follows up for delinquent submittals. If the audit is not received within 30 days of the due date, an electronic "late" reminder is sent to the HCP/MAI contractor's Program and Fiscal Contact. Electronic reminders are sent every 30 days until the audit is received.	The HCP/MAI FA tracks all audits received and follows up for delinquent submittals. If the audit is not received within 30 days of the due date, an electronic "late" reminder is sent to the HCP/MAI contractor's Program and Fiscal Contact. Electronic reminders are sent every 30 days until the audit is received.
Received Audits	The HCP/MAI FA has 30 days to complete the review of the contractors'/CBO audit report and issue an electronic memo of compliance or deficiency. An electronic copy of the memo is kept with the electronic copy of the audit report. Contractor and Subcontractor audits are reviewed internally by the OA RW Part B Fiscal Analyst.	The HCP/MA FA has 30 days to complete the review of the contractor's/CBO audit report and issue an electronic memo of compliance or deficiency. An electronic copy of the memo is kept with the electronic copy of the audit report. Contractor and Subcontractor audits are reviewed internally by the RW Part B Fiscal Analyst.

Deficient Audits	The A-133 audit submitted without the minimum components is a deficient report. When required components are missing from an audit report, RW Part B Advisor sends an e-mail to the HCP/MAI contractor identifying the deficient items.	The Financial Statement audit submitted without the minimum components is a deficient report.
Disclosures	The RW Part B Fiscal Analyst and RW Part B Advisor may look for disclosures in the A-133 audit that cite any of the following: 1) ongoing concerns/problems; 2) unresolved legal issues; 3) questioned costs; 4) financial hardship; 5) lack of compliance with contracts, laws or regulations; 6) ineffective internal control measures and; 7) control board turnover.	N/A
Corrective Action Plan (CAP) Request and Response	When there are deficiencies or findings needing correction, the RW Part B Advisor will e-mail the HCP/MAI contractor requesting a Corrective Action Plan (CAP). The HCP/MAI contractor must send a written CAP to the RW Part B Advisor within 30 days, indicating how the finding(s) will be addressed (if a copy of the CAP was not included with the submission of the audit). The HCP/MAI Fiscal Analyst keeps track of the CAP and the RW Part B Advisor monitors compliance to the CAP during yearly monitoring site visit.	When there are deficiencies or findings needing correction, the RW Part B Advisor will e-mail to the HCP/MAI Contractor requesting a Corrective Action Plan (CAP). The HCP/MAI contractor must send a written CAP to OA within 30 days, indicating how the finding(s) will be addressed. The HCP/MAI Fiscal Analyst keeps tracking of the CAP and the RW Part B Advisor monitors compliance to the CAP during yearly monitoring site visit.

RESOURCES

The Resource section provides quick and easy access via links to HIV/AIDS organizations, programs and services. The section provides a list of commonly used acronyms and reference website links contained within this document for Funding Year 2013-2014.

If you require further clarification or technical assistance, contact your RW Part B Advisor listed on the OA website at:

http://cdphinternet/programs/aids/Documents/11MAD3cCareAdvisors.pdf]

Pacific AIDS Education Center	http://paetc.org/main/
California HIV/AIDS Service Referral	http://www.cdcnpin.org/ca/
California Statewide Training and Education Program (CSTEP)	http://www.apiwellness.org/cstep.html.
California STD/ HIV Prevention Training Center (CA PTC)	http://www.stdhivtraining.org/
HAB	http://www.hrsa.gov/about/organization/bureaus/hab/index.html
HAB Performance Measures	www.Hab.hrsa.gov/deliverhivaidscare/habperformmeasure.html
HRSA Manage Your Grant	http://hab.hrsa.gov/manageyourgrant/policiesletters.html
HRSA Quality Improvement Tools	www.hrsa.gov/quality/toolsresources.html
Low Income Health Plan (LIHP)	http://cdphinternet/programs/aids/Pages/OARyanWhiteDHCSLowIncomeHealthProgram.aspx
National Monitoring	http://cdphinternet/programs/aids/Pages/HCPNatlMonitoringStds

Standards	.aspx
Needs Assessment Summary	www.cdph.ca.gov/programs/aids/Pages/tOAHCPSDPsp.aspx
OA	http://cdphinternet/programs/AIDS/Pages/Default.aspx
RW Part B Advisors	http://cdphinternet/programs/aids/Documents/11MAD3cCareAdvisors.pdf
OA HCP Providers	www.cdph.ca.gov/programs/aids/Pages/OACareProviders.aspx
Pacific AIDS Education and Training Center (PAETC)	http://paetc.org/main/http://www.paetc.org/main/
Quarterly Narrative Reports (link includes all report forms)	http://cdphinternet/programs/aids/Pages/HCPForms.aspx
Service Delivery Plan (SDP)	http://www.cdph.ca.gov/programs/aids/Pages/tOAHCPSDPsp.aspx
The National HIV Telephone Consultation Service (Warmline)	http://www.nccc.ucsf.edu/about_nccc/warmline/

ACRONYMS

AETC	AIDS Education and Training Centers Program
API	Asian and Pacific Islander Wellness Center
ADAP	AIDS Drug Assistance Program
ARIES	AIDS Regional Information and Evaluation System
ARV	Antiretroviral (Therapy)
CARE	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CQM	Clinical Quality Management
CSTEP	California Statewide Training Education Program
DHCS	Department of Health Care Services
EIIHA	Early Identification of Individuals with HIV/AIDS
EIS	Early Intervention Services
EMR	Electronic Medical Record
FA	Fiscal Agent
FPL	Federal Poverty Level
HAB	HIV/AIDS Bureau
HCC	Health Care Coverage Initiative
HCR	Health Care Reform
HHS	Health and Human Services (Agency)
HIPAA	Health Insurance Portability and Accountability Act
HIS	Indian Health Services
HOPWA	Housing Opportunity for Persons with AIDS
HRSA	Health Resources and Services Administration

LHJ	Local Health Jurisdiction
LIHP	Low Income Health Program
LTC	Linkage to Care
MAI	Minority AIDS Initiative
MCE	Medicaid Coverage Expansion
MM	Management Memos
NHAS	National HIV/AIDS Strategy
OA	Office of AIDS
QM	Quality Management
RSR	Ryan White HIV/AIDS Program Services Report
RW Part B	Ryan White, Part B
SDP	Service Delivery Plan
SFS	Sliding Fee Scale
SOW	Scope of Work
SPNS	Special Projects of National Significance Program
TGA	Transitional Grant Areas
VA	Veteran's Administration
WICY	Women, Infants, Children, and Youth

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Standards of Care

Common Standard

Early Intervention Services

Food Bank - Home-Delivered Meals

Health Education Risk Reduction

Hospice Services

Housing

Linguistic Services

Medical Case Management

Medical Nutrition Therapy

Medical Transportation

Mental Health Services

Non-Medical Case Management

Oral Health

Other Professional Services

Outpatient Ambulatory Health Services

Outreach

Psychosocial Support Services

Referral for Health Care and Support Services

Substance Abuse Outpatient Care

Substance Abuse Services (residential)

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Common Standards of Care

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Common Standards of Care" for all services of HIV Care Program (HCP), a program of the California Department of Public Health, Office of AIDS (OA), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. This document highlights each of the requirements and standards that must be followed by any provider receiving HCP (Ryan White) funding. Common standards addressed here include client eligibility and consent, staffing, cultural and linguistic competency, service management and closure, and quality assurance. These standards must be met or exceeded for all HCP services in all jurisdictions. Users should refer to service category-specific standards for more detailed or additional requirements.

How This Document is Organized

Within this document, the Common Standards of Care are described in terms of (1) Use of HCP Funds, and (2) Requirements.

Use of HCP Funds

1. All clients served by providers funded by HCP shall receive services that:
    - Are accessible to all persons living with HIV who qualify and meet eligibility requirements
    - Include a comprehensive intake process that establishes client eligibility, collects client information, and comprehensively informs them about available services
    - Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff
    - Are culturally and linguistically competent
    - Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV
    - Promote continuity of care, client monitoring, and follow-up
    - Ensure a fair process of grievance review and advocacy
2. Providers must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients (i.e., Ryan White must be the "payer of last resort").

3. HCP funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with HCP funds and the intended client's HIV status.

4. Affected individuals (partners and family members not living with HIV) may be eligible for HCP services in limited situations, but these services for affected individuals must always directly benefit people living with HIV. For more information see HRSA PCN 16-02 and ARIES Policy Notice C5.

Requirements

All service providers receiving funds to provide HCP services are required to adhere to all standards described in this *Common Standards of Care*. In addition, they must adhere to any service category-specific standards described in the standard of care for that service category. Monitoring is conducted on a yearly basis through desk review and onsite monitoring.

ARIES - AIDS Regional Information & Evaluation System

ARIES is a centralized, secure, online HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers throughout California to plan, manage, and report on client data. HCP frequently uses ARIES to conduct monitoring of these Standards of Care.

Intake

Client intake consists of four key steps:

- Eligibility screening
- Consents and notifications
- Client registration
- Screening for service needs / acuity

Eligibility Screening

The certification process verifies that a client's HIV status, residency, income, and insurance status meet eligibility requirements and ensures that HCP is the payer of last resort. Initial eligibility certification includes documentation of the following:

- **Proof of HIV-positive status:** At the first certification, clients must provide proof of HIV-positive status. This must consist of at least one of the following:
    - HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.

        - ***NOTE:*** *Rapid linkage to care after diagnosis is a top priority and this is not intended as a barrier; while agencies must have proof of HIV diagnosis and eligibility established before providing HCP-funded services, there is no legislative requirement for a "confirmed" HIV diagnosis prior to care (i.e. initial HIV screening test results is sufficient, though confirmatory testing should be ordered on first visit. See clarifying letter from HRSA on this issue).*
    - Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
        - Letters already in client charts that do not meet this standard are grandfathered in; this requirement for letters applies to new intakes conducted after April 1, 2018.
    - Diagnosis Form (CDPH 8440) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.
- **Proof of Residence:** Individuals eligible for HCP services must reside in the State of California. Acceptable residency verification consists of the client's name and address on one of the following:
    - Current utility bill
    - Current rental or lease agreement
    - Official document, such as a voter registration card, Medi-Cal beneficiary letter, recent school records, property tax receipt, unemployment document, etc.
    - California driver's license or California Identity Card
    - Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as their residence. The letter must be on letterhead and signed by a staff person affiliated with the service agency or clinic
    - If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates they are homeless with no connection to any other service provider. In this situation, a referral to assist the client in securing shelter or housing should be a priority. For an example of an affidavit form see the ADAP form CDPH 8727 / CDPH 8727 SP.
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. HCP financial eligibility matches the financial eligibility defined by ADAP in Health and Safety Code (HSC) § 120960. Currently, HSC § 120960

defines income eligibility as clients with modified adjusted gross income which does not exceed 500 percent of the federal poverty level per year based on family size and household income. Acceptable income verification includes one of the following:

  - One pay stub from within the last 6 months
  - 1040 Form or W-2 from the previous year
  - Signed and dated letter from a source of earned income, including the client's name, rate, and frequency of pay
  - One bank statement showing income from applicable source(s) (i.e. through direct deposit)
  - Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) letter, or dated screenshots of client benefit program
  - Document confirming other government assistance (e.g., Medi-Cal military/veteran pension benefits, unemployment benefits, child support payments)
  - Investment statement showing interest earned
  - Letter of support signed and dated by an individual providing financial and other living support (food, clothing, and/or shelter) to the client
  - If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates zero income, or attests to earned income not otherwise confirmed by the above. For an example of an affidavit form see the ADAP form CDPH 8441/ CDPH 8441 SP.

- **Insurance Status:** Clients seeking any services through HCP programs must provide documentation of health insurance status. Acceptable verification includes one of the following:
  - Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable
  - Dated screenshots of client insurance status verification using an official insurance screening system
  - Denial letter from Medi-Cal
  - Tax statement documenting no insurance, per ACA requirements
  - Statement signed and dated by the client indicating they are not covered by insurance. If client is employed, the statement must include the reason the employer does not provide insurance

- **Documentation of Need:** In order for providers to pay for services covered or partially covered by Medi-Cal, Denti-Cal, private insurance, or other eligible benefits and retain HCP as the payer of last resort, client charts must include the following:
    - A description of the need for additional medically necessary services, beyond what the client's health care coverage or other benefits provide
    - Documentation indicating that such services are only partially covered or unavailable in a timely fashion through the client's health care coverage or other benefits

  NOTE: *Contractors* and providers *should be aware that HCP funds cannot be used to pay for services provided by a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.*

  REMINDER: All HCP providers who provide services that overlap with Medi-Cal or Denti-Cal must be certified to receive Medi-Cal or Denti-Cal payments or are able to document efforts under way to obtain such certifications.

- **Screening for Service Needs / Acuity:** At the time of client intake into any HCP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Screening for services and client acuity can be done using the tools and/or scales of the local jurisdiction, but tools/scales must be standardized within the jurisdiction. Referrals should be made for any services identified as needed but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. All referrals must be documented.

Exceptions

In the case of clients with urgent/emergent service needs, it is acceptable to begin providing services having only obtained proof of HIV diagnosis (initial HIV screening test is acceptable per HRSA) and signed consents (see below); in these cases, full eligibility screening and all other requirements must be met within 30 days of service initiation. If this occurs, documentation in the client chart of the circumstances around the need for urgent/emergent services is required.

Monitoring

Eligibility Screening - Client eligibility, including HIV-positive status, residency, income, and insurance status must be entered into ARIES. Documentation of service needs and acuity must be documented in client chart(s), and made available during site visits.

ARIES Reference

Proof of Diagnosis Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. HIV Letter of Diagnosis 2. Proof of Diagnosis Upload copy of corresponding document *ARIES Policy Notice No. C3*	Residency Eligibility Tab Eligibility Documents Sub-tab Pick one: 1. Picture ID 2. Proof of Residency
Income Eligibility Tab Financial Sub-tab Enter: Household Monthly Income # of People in Household	Insurance Eligibility Tab Insurance Sub-tab Click *New* Enter: Start Date Source Payer *ARIES Policy Notice No. C4*

Consents

Prior to receiving services, clients must sign the following consent forms:

- **Agency Consent for Service:** Clients must sign a consent form indicating they consent to receiving services from the agency
- **ARIES Consent:** Providers must obtain a completed ARIES Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Clients must indicate whether they want to share their ARIES data with other ARIES-using agencies at which they receive services. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share choice.
    - The form must be renewed once every three years or whenever clients want to change their data-sharing choice. For more information, refer to ARIES Policy Notice C1 on Client Consent and Share Options.

On an as-needed basis, the following must also be documented via forms signed by the client:

- **Consent to Release Confidential Information (not the same as ARIES Consent Form):** When disclosure of confidential information is requested by the client, or

required for care coordination or other necessary components of high-quality service provision, the client must be informed of this intent to share information and must provide written consent before the information is shared. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.

- **Authorization to Exchange Confidential Information (not the same as ARIES Consent Form)**: Similar to the consent to release confidential information, when appropriate, clients may also provide consent for regular exchange of information about their case between providers as it helps with care coordination. Again, the client must provide written consent **before the information is shared**. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
    - *NOTE:* Case conferencing between staff of the same organization which takes place on a regular basis and is a standard part of many HCP services does not require additional authorization. However, if staff from outside the organization are needed to conduct thorough case conferencing, prior authorization to exchange information would be required.

All signed consents must be kept in the client's file, and the client must receive a copy.

Monitoring

Agency Consent for Service - Signed consent forms shall either (1) be uploaded to ARIES, or (2) retained in client chart(s) and available for review upon request.

ARIES Consent - ARIES Consent Forms must be logged into ARIES and the Share option must reflect the client's choice as reflected on the form. For more specifics, see ARIES Policy Notice C1.

Authorization to Exchange Confidential Information - Documentation of consent to release or exchange confidential information must be retained in client chart(s) and available for review upon request.

ARIES Reference

ARIES Consent Form
Eligibility Tab
Eligibility Documents Sub-tab
Pick ARIES Consent Form / Enter date

Share Option
Agency Specifics Tab
Agrees to Share Date / Select Yes or No

Notifications

As a part of HCP services, clients should be notified of the following:

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of HCP services
- **Re-engagement services** are routinely provided by this provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services
- **After-hours or weekend options** that are available to clients during an emergency (i.e. an on-call number, answering service, or alternative contacts in other agencies)
- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction, and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance
- **Client Rights and Responsibilities**: Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum rights and responsibilities outlined later in this Common Standards of Care document.

Clients must receive a written copy of all notifications provided during intake.

Monitoring

Client Notification - Client notification of case conferencing, re-engagement services, and after-hours / weekend emergency options must be documented through submission of agency written policies and procedures and forms related to these notifications.

Client Notification with Signature - Client notification of HIPAA, client grievance procedures, and rights and responsibilities must be documented in client chart(s) and available upon request for review. There must be documentation that the client has received these notifications; documentation shall be through client signature that they have received and acknowledged these notifications.

Client Registration into ARIES

HCP providers must report on the HCP clients they serve using ARIES.

For new clients, HCP providers must explain the "share" options to the client and obtain a signed ARIES Consent Form (see ARIES Policy Notice C1). Providers shall also collect the client's identifiers to initiate client registration in ARIES. Identifiers include all of the following:

- First Name
- Middle Initial
- Last Name
- Mother's Maiden Name (see **ARIES Policy Notice C2**)
- Date of Birth
- Current Gender

To initiate ARIES registration, the HCP provider enters these identifiers into ARIES. If the client already exists in ARIES as a share client, ARIES will open the existing client record for the provider. If the client is non-share or new to ARIES, ARIES will create a new client record for the provider.

While the client is enrolled in the agency, the HCP provider is required to collect and enter into ARIES certain data elements for the annual Ryan White Services Report (RSR). These data elements are identified with large red asterisks in ARIES. For more details about and provider requirements for the RSR, please visit https://careacttarget.org/category/topics/ryan-white-services-report-rsr.

Timeframe

Intake appointments for new clients should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days from first client referral. A referral can be from another professional or self-referral. Agencies must have a tracking method to record when first contact was made so it can be entered in to ARIES. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours as client missed appointments have been linked to future poor health outcomes. Missed appointments and attempts to reschedule must be documented in the tracking log or the client chart. For appointments made later than 10 days from first client referral, the reason for the delay must be documented in the client chart.

Monitoring

Timeframe for intake appointments for new clients will be monitored through site visit discussions regarding MOUs with referring agencies and internal processes. For those who do not have an automated system to track new referrals, a log of such referrals must be kept and available for review.

ARIES - data must be recorded for ARIES fields *Referral Date, Agency Enrollment Date,* and *Service Date.* Reasons for any delay in intake appointments beyond 10 days – or any exceptions made for urgent/emergent services per above – must be documented in client chart(s) and available for review upon request.

ARIES Reference

Demographics Tab Agency Specifics Sub-tab	Services Tab Enter date of first service
1. Step One, enter: • Referral Date (date of first contact) • Referral Source • Other 2. Step Two, enter: • Agency Enrollment Date	

Recertification

Eligibility recertification must be repeated at least every six months. At the six-month recertification, a client can self-attest that they continue to meet the established guidelines by signing a form with an appropriate statement. However, complete eligibility documentation is required 12 months after the initial intake or last annual recertification. (for an example of a self-attestation form see the ADAP form CDPH 8723 / CDPH 8723 SP):

- **Proof of Residence:** Continued proof of California residency must be documented. Acceptable residency verification is the same as that required for initial eligibility certification.
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. Acceptable income verification is the same as that required for initial eligibility certification.
- **Insurance Status:** Clients must provide documentation of health insurance status. Acceptable verification is the same as that required for initial eligibility certification.

Screening for Service Needs / Acuity: At least every six months, all clients must be re-assessed for service needs and acuity level. Screening can be done using the tools and/or scales of the local jurisdiction, but these tools/scales must be standardized within the jurisdiction and documented in the client chart. Services provided to that client should be adjusted according to any changes in client needs/acuity since the last assessment.

Monitoring

Six-Month Recertification - Eligibility recertification of residency, income, and insurance status must be documented at least every six months. Client self-attestation forms can used for six-month recertification and can be uploaded to ARIES or saved in the client file.

Annual Recertification - Annual recertification of residency, income, and insurance status must be documented in ARIES. Agencies must have updated documentation of these elements in client chart(s), available for review upon request.

ARIES Reference

Step One:	Step Two:
Go to Eligibility Tab Update information on all three sub-tabs as needed (see eligibility section above, HIV Diagnosis does not need to be repeated) Upload self-attestation (optional)	Go to Program Tab, Ryan White sub-tab Enter recertification date and information Note “recertification” in comment field.

Service Access, Management, and Closure

Client Access

Services must be planned and implemented in a way that ensures an accessible environment. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments
- Not be restricted on the basis of age, gender, sexual orientation, race, ethnicity, disability, past or current health condition, ability to pay fees, residence, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act (except as required for eligibility purposes.)

Service Management

Services must take into account client needs and remove barriers to clients’ ability to meet the requirements of their care/treatment plans, as follows:

- Services must be managed to achieve:
    - Accessibility
    - Effectiveness
    - Reliability
    - Timeliness
    - Appropriateness to the needs of clients

Monitoring

Accessibility - Existence of adequate physical accommodation(s) for disabilities and/or impairments of clients, will be verified during site visits.

- Services must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to:
    - Access to non-HCP-funded services
    - Resource guides to low-cost/free medical and support services, including those not offered as part of HCP

In addition, services must be transparent and fiscally responsible:

- Services should be planned, managed, and monitored to avoid the need for:
    - Urgent or emergency services
    - Service interruption
    - Needing emergency or unplanned funding to continue services during contract periods.
- Data collection and documentation of all services must be manually entered or imported into ARIES for accounting, reporting, compliance, and evaluation purposes. The optimum goal for entering data into ARIES is in real-time. Some providers may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Providers that are unable to enter data in real-time have up to two weeks from the service date to enter the data. For more information, please see ARIES Policy Notice E1.
- Program directors and managers shall ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.

- Service providers must have a way to obtain client input and feedback on an annual basis. The ideal method would be a "client advisory board" that consists of representation of the population served and provides input to the delivery of services. In lieu of an advisory board, providers can provide a visible suggestion box which is locked or other similar client input mechanism such as client satisfaction survey.

Monitoring

Client Input – copies of minutes from annual client advisory board meetings, or client suggestions or surveys will be reviewed during site visit.

Case Closure

In some cases (e.g. a client who is incarcerated for longer than 6 months) a client file may be made "inactive," able to easily be returned to "active" status when the client returns to services as expected. A client file may be permanently "closed" under certain conditions. The reason for and circumstances around all closure actions must be documented in the client file or in ARIES. Acceptable reasons for client file closure are:

- The client has requested transfer of services to another agency
- The client has died or moved out of California
    - Providers are strongly encouraged to report clients who have died or moved out of California to the HIV surveillance coordinator at the local public health department. This will allow the coordinator to update the surveillance system and ensure that the county's data accurately reflect who is in care.
    - Providers should attempt to assist the client with identifying a source of care in the jurisdiction they are moving to.
- The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period.
    - Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities.
- The client is no longer eligible or has failed to provide updated documentation of eligibility status

    - Providers must be proactive in helping clients obtain this information. No client should be discharged before staff have assisted the client with gathering the required documentation.
- The client's actions have put the agency, staff, and/or other clients at risk
- There is evidence of client fraud or deliberate misuse of services
- Additional service-specific circumstances for closing a client file may be found in the Standard of Care for an individual service.

File Closure: Agencies should close a client's file according to the written policies and procedures established by the agency.

- **Prior to closure** (for reasons other than death), the agency must attempt to inform the client of the appeal process and re-entry requirements into the system, make clear to the client the consequences of closing the case, and offer to facilitate transfer of information to a new provider.
- **Prior to forced disenrollment and case closure due to evidence of abusive behavior, client fraud, deliberate misuse of services, or service ineligibility**, the client must:
    - Be given at least 10 days' notice before disenrollment, except in cases of abusive behavior that poses serious physical danger to staff or clients
    - Be sent a letter that verifies the disenrollment date and reason for the action, along with information about the procedure for grievance/appeals. This letter must be legible, signed, and dated, and a copy must be kept in the client record

Record Maintenance: Client files must be retained in a secure place for a minimum of three years, or later as is required by law for your facility type, after a case is closed. After that time period, they must be disposed of securely through confidential means such as cross cut shredding and pulverizing.

Monitoring

File Closure - Appropriateness of file closure will be monitored via chart review during in-person site visits. Agency policies and procedures for file closure, as well as compliance with record maintenance standards, will be monitored through agency submission of applicable written policies and procedures.

Client Rights and Responsibilities

Information in this section must be included in a client Rights and Responsibilities form. Clients must sign an acknowledgement of having received this information.

All eligible clients have the right to:

- Request and receive approved services consistent with their care/treatment plan
- Receive services that are reliable, timely, respectful, and appropriate to their situation, culture, health status, and level of disability
- Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities
- Participate in decisions about their care and obtain information about treatment options
- Refuse care
- Have their healthcare information be treated confidentially
- Review their client records (including medical records) and request that any inaccurate, irrelevant, or incomplete information be changed as per local policies and procedures.

Clients are responsible for:

- Providing documentation to verify their eligibility for HCP services
- Being involved in their healthcare and adhering to their treatment plan
- Disclosing relevant information
- Clearly communicating their wants and needs
- Treating service providers appropriately and with respect at all times
- Arranging services in a way that avoids emergencies whenever possible
- Maintaining periodic contact with their relevant service provider
- Following provider written policies and procedures and guidelines
- Following written or verbal instructions regarding treatments, activities, safety policies, and utilization of services

Monitoring

Client Rights and Responsibilities – A copy of the client form outlining Client Rights and Responsibilities must be provided. Review of client acknowledgment will be done via chart reviews.

Staffing Requirements and Qualifications

Education / Experience / Supervision

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or HCP Standards of Care. See each specific service standard for detailed requirements by service.

Monitoring

Staff Education and Experience - Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Staff Orientation and Training

Initial: All staff providing direct services to clients or making decisions about HIV service must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Navigation of the local HIV system of care, including ADAP
- Confidentiality and Security
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health

Other topics may include:

- Psychosocial issues
- Health maintenance for people living with HIV
- Client service expectations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Confidentiality agreements by staff must be reviewed and re-signed annually.

Training requirements and updated confidentiality agreements must be clearly documented, and completed trainings must be tracked for monitoring purposes.

Monitoring

Staff Orientation and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided, dates of trainings, and dates of refreshed confidentiality agreements; this list must be available for review during site visits or upon request.

Cultural and Linguistic Competency

According to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), culturally and linguistically competent services are those that "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." Providers shall provide services that:

- Treat people living with HIV with respect, and are skilled and culturally-appropriate for the communities served
- Reflect the culture of the community served
- Comply with American Disabilities Act (ADA) criteria
- Are in a location and have hours that make it accessible to the community served
- Are provided in the client's primary language. If that language is not English, interpretation must be provided by a staff member or other means
- Are provided in areas with posted and written materials in appropriate languages for the clients served
- Provide interpreters or access to real-time interpreter services (including phone, Skype, etc.) For HIPAA covered services, interpretation services must follow HIPAA requirements; family and friends should not be used for interpretation. For non-HIPAA covered services, family and friends should only provide interpretation as a last resort and with the prior permission of the client.

Monitoring

Culturally and Linguistic Competency - Compliance with CLAS Standards, including ADA criteria and accessible location/hours of services, will be monitored via direct observation of site setup and function during site visits.

Fiscal Responsibility

Payer of Last Resort

Federal legislation states that Ryan White funds are the payer of last resort. This means that no HCP funds can be used for services that could reasonably be paid for or provided by another funding source. Providers are required to screen all clients for eligibility for other programs such as Medi-Cal, Denti-Cal, private insurance (including Covered California plans), Cal-Fresh (SNAP), etc. While there are limitations on when clients can sign up for Covered California as defined by open enrollment dates, providers should be aware that there are special enrollment periods for certain circumstances (e.g., divorce and loss employment). There are no restrictions when a person can sign up for Medi-Cal or Cal-Fresh as these programs have on-going enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist HCP clients with the process of signing up for those programs.

Ryan White legislation also states that other funding sources must be utilized prior to Ryan White funds being used. However there are times that HCP can pay for services covered by other funding. To pay for services covered by Medi-Cal, Denti-Cal, private insurance or other programs, service providers must provide documentation of the need for additional services beyond what the client's health care coverage or other benefits provide or if an exception was made due to no available provider. Funds cannot be used to pay for services from a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.

The Department of Veterans Affairs (VA) – HCP service providers may not deny services, including prescription drugs, to a veteran who is otherwise eligible to receive HCP services. Providers may not cite the "payer of last resort" language to compel a veteran living with HIV to obtain services from the VA health care system or refuse to provide services. However, the VA system differs from other payers because of its unique structure as an integrated care system under which the VA may serve as both payer and provider. The VA is not an insurance or entitlement program. Providers should work with the local VA to ensure clients receive all needed core and support services. HCP can pay for services that are unavailable from the VA. For more information see HRSA Policy Notice 16-01.

Indian Health Services (IHS) programs are exempt from the payer of last resort mandate. For more information see HRSA Policy Notice 07-01.

Quality Assurance

Service Evaluation

Each service provider is responsible for evaluating and reporting its performance relative to care standards, and is subject to client chart, utilization, and other types of audits. Service providers must:

- Collect and examine client satisfaction data, and have a process to act on the information reported
- In response to any findings as part of routine HCP monitoring, develop and implement a Corrective Action Plan (CAP)
- Maintain a grievance procedure which provides for the objective review of client grievances and alleged violations of care and service standards
    - Clients must be routinely informed about and assisted in utilizing this procedure
    - Clients must not be discriminated against for utilizing the grievance procedure
- Have a client complaint procedure which addresses issues not appropriate to the grievance procedure. Complaints will be investigated and responded to in a timely and respectful manner according to local written policies and procedures. Documentation of investigation and response should be maintained in writing and kept separate from the regular client file

Monitoring

Quality Assurance –A copy of the Grievance Policy must be provided to HCP. Oversight of submitted client grievances will occur during site visits. The Grievance Policy may be incorporated into the Client Rights and Responsibility form

Clinical Quality Management - For clinical services, comply with requirements in the California Ryan White Part B Clinical Quality Management Plan

HIPAA Compliance and Non-HIPAA/HITECH Contractors/Providers

- All providers of HIPAA-covered services will comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All HIPAA regulations must be followed when interacting with or on behalf of a client, and with regards to record maintenance.
- All non-HIPAA covered contractors and providers (including tax preparation professionals, accountants, law firms, etc.) must comply with the Information Privacy and Security Requirements set forth in the HCP/MAI contract.
- All contractors and providers must have their employees and volunteers sign the Agreement by Employee/Contractor to Comply with Confidentiality Requirements (CDPH 8689) upon hire prior to having access to any confidential information and on an annual basis thereafter.

Monitoring

Confidentiality Compliance - Signed agreements to comply with confidentiality requirements (CDPH 8689) must made available during site visits.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Early Intervention Services (EIS)

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Early Intervention Services" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Early Intervention Services (EIS), and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Early Intervention Services (EIS) for Part B is designed to identify individuals who are living with HIV and link them into care as quickly as possible. This is done through: outreach, counseling and testing, and information and referral. The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service.

Key Activities

EIS *must* include all of the following four components. All of these components must be available in the service area, even if not directly provided by the HCP contractor or provider:

- **Targeted HIV testing** to help persons who are unaware of their HIV infection status learn of their HIV status and receive referral to HIV care and treatment services if found to living with HIV, or to HIV prevention services, including PrEP if appropriate based on ongoing risk, for those found to be HIV negative
    - Services must be coordinated with other HIV prevention and testing programs to avoid duplication
    - Testing paid for by EIS cannot take the place of testing efforts that could be paid for by other sources
- **Referral services** to improve HIV care and treatment services at key points of entry
- **Access and linkage** to HIV care and treatment services such as HIV Outpatient/ Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- **Outreach Services and Health Education/Risk Reduction** related to HIV diagnosis

Objective

EIS is intended to identify people at the earliest point possible in the course of their HIV infection, and to quickly link them to medical and support services necessary to support treatment adherence and maintenance in medical care.

All EIS activities must be geared to priority populations which should be identified by using surveillance and continuum of care data.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards for EIS staff. Regardless of education/training, staff should be experienced in some or all of the following:

- Outreach
- HIV counseling and testing
- Prevention case management
- HIV case management
- Health education

All EIS staff must be trained and knowledgeable about HIV, and familiar with available HIV resources in the area. They should have good communication skills and ideally be culturally and linguistically competent for the community served. Staff providing HIV testing must comply with all State of California rules and regulations, including:

- Meeting state requirements for qualifications and/or certification
- Obtaining informed consent
- Appropriate test kit training and proficiency testing
- Case reporting
- Documentation

Individual supervision and clinical guidance must be available to EIS staff as needed.

Monitoring

Education/Experience/Supervision

Staff experience meeting the minimum requirements for service provision in this category must be kept in personnel files, with hire date for review during site visits.

Test Counselors- All staff conducting testing must be in compliance with State of California rules and regulations.

Individual supervision and clinical guidance available to staff will be monitored through discussion during site visits.

Staff Orientation and Training

Initial: All staff providing EIS must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, including HIV transmission, care, and prevention
- HIV counseling and testing
- Privacy requirements and HIPAA regulations
- Navigation of the local HIV system of care, including access to PEP and PrEP
- Cultural sensitivity/competency trainings related to the delivery of HIV services

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Service Characteristics

EIS must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

Eligibility Screening: Unlike all other categories of HCP services, some EIS may be provided without eligibility screening. These include:

- HIV testing
- Outreach services
- Initial referral services

EIS can be provided on a one-time-only or short-term basis only; longer-term services should be provided through other service categories. If EIS staff continue to have contact

with the client following these initial services, the client must be screened for eligibility as described in the Common Standards of Care and transitioned to a different service category.

HIV testing: HIV testing may be provided in a variety of settings. Regardless of setting, testing must comply with State of California standards and regulations. Testing should be coordinated with local HIV prevention programs to avoid duplication of effort and ensure priority populations are being served. HCP will only fund HIV testing that is in compliance with OA Prevention Branch guidance.

Referral / Linkage: Refer clients identified through EIS as living with HIV to medical care, case management, benefits counseling, and other services necessary to maintain or improve health outcomes using a warm hand off where possible. Documentation of that referral must be in the client file and available upon request.

Outreach: Outreach is intended to identify people with unknown HIV status or those who know their status but have fallen out of care, so that they may become aware of and be enrolled in care and treatment services. Outreach should:

- Utilize local HIV surveillance data to locate individuals who have not yet been linked to care
- Utilize ARIES data or local medical data to identify clients with missed appointments or who have fallen out of care;
- Be coordinated with HIV prevention programs to avoid duplication of effort;
- Focus on priority populations known to be at disproportionate risk based on local epidemiologic data, including partners of people living with HIV; and
- Be conducted when/where people at high risk for HIV infection will be reached.

Health Education / Risk Reduction: The purpose of health education and risk reduction services is to educate clients living with HIV about how to reduce the risk of transmitting HIV to others. EIS staff should provide education and informative materials about these and related topics, including testing and the availability of related HIV services.

Partner Services: Per CDPH Management Memo 15-06, HCP providers funded for EIS must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

HIV Testing - HIV testing must be performed in compliance with State of California standards and regulations; this will be monitored via submission of the staffing budget for this service category. Coordination with local outreach/prevention programs will be monitored via desk audit of program budget forms.

Referral / Linkage – Refer to Client Monitoring below.

Outreach - Utilization of local HIV surveillance data for outreach, coordination with local outreach programs, focusing on priority populations for outreach, scheduling of outreach to occur where/when people at high risk for HIV are present, and the availability and distribution of educational/informational materials will be monitored through observation and discussion during site visits.

Partner Services - Existence of a protocol and process for Partner Services referral and counseling will be monitored by submission of policy/protocol documentation to HCP. Implementation of the protocol (i.e. that clients are actually offered Partner Services information and referrals) will be monitored through observation and chart review during site visits.

Client Monitoring

While EIS is intended to be short-term, staff should follow-up on referrals and linkages within 10 days to verify the client has been established in that service. At least three attempts should be made to verify linkage to the service before considering the client lost to follow up. Once successful linkage is verified, future follow-up should be conducted by other providers or under a different service category. These efforts must documented.

Monitoring

Client Monitoring - Information about referrals and related follow-up will be monitored through ACE or ARIES; data must be recorded in the Referral tab of either location in the *Referral Date, Outcome*, and *Outcome Date* fields.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Food Bank / Home-Delivered Meals

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Food Bank / Home-Delivered Meals" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Food Bank/Home-Delivered Meals, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Food Bank/Home-Delivered Meals refers to the provision of actual food items, hot meals, or vouchers to purchase food. This also includes the provision of essential non-food items. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service, covered under the Medical Nutrition Therapy standard.

Allowable costs under the Food Bank/Home-Delivered Meals standard include:

- Food items
- Hot meals
- Vouchers used to purchase food
- Nutritional supplements, such as Ensure, may only be used in addition to food and not as the only offering to a client.

Allowable essential non-food items are limited to the following:

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

Unallowable Activities

Unallowable costs under the Food Bank/Home-Delivered Meals standard include:

- Household appliances
- Pet food
- Alcohol, tobacco, or cannabis products

- Clothing
- Other non-essential products
- Cash payments to clients
- The provision of food is essential to wellbeing and must be based on need. It should not be used as an incentive to motivate clients to attend on-going appointments or take medication

Monitoring

Allowable Costs - Verification that funds are being used only for allowable costs will be conducted via submission of budgets and invoices, and HCP desk audit of services.

Fiscal Management

There are additional requirements when utilizing vouchers or store gift cards.

- Providers must ensure that vouchers or store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services. Some stores may require program vouchers to exclude certain products such as tobacco and alcohol.
- General-use prepaid cards are considered "cash equivalent" and therefore unallowable. Such cards generally bear the logo of a payment network (e.g., Visa, MasterCard, or American Express) and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are co-branded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore not allowed.
- Providers must have systems in place to account for disbursed vouchers. The systems must track the client's name, the staff person who distributed the voucher, the date of the disbursement, and serial number and the voucher dollar amount. These data elements can be tracked on the ARIES Services screen if no other tracking system is available.
- Providers should only buy vouchers in amounts that are reasonable for use in the contract year. In no case should use of vouchers lead to large amounts of Ryan White monies being held over to new contract years.

Monitoring

Fiscal Management - Management of vouchers per the bullet points above will be monitored through agency submission of written policies and procedures for accounting of disbursed vouchers, desk audit of submitted budgets and invoices related to purchase of specific types of vouchers or gift cards, and site visit verification of the use of these products.

Objective

Food Bank/Home-Delivered Meals provides access to healthy and nutritious food or meals through the distribution of actual food or food vouchers in order to help maintain caloric intake and balanced nutrition in a manner consistent with each client's care plan when applicable.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards. Staff preparing food must be familiar with safe food handling practices and meet any federal, state, or local requirements around food preparation.

Staff Orientation and Training

Initial: All Food Bank/Home Delivered Meals staff must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- Safe food handling procedures
- Confidentiality
- Knowledge of key points of entry for other Ryan White services

Monitoring

Training - Training on safe food handling procedures will be monitored through submission to HCP of evidence of appropriate training, with a date of training prior to the start of service provision.

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Agency

Any agency providing Food Bank/Home-Delivered Meals must comply with federal, state, and local regulations, including any required licensure or certification for the provision of food bank services and/or home-delivered meals. Where applicable, this also includes adherence to any necessary food handling standards or inspection requirements.

Monitoring

Regulations - Agencies providing these services will be asked to provide to HCP a copy of their environmental health inspection, as well as any applicable licensure/certification. If these items are not applicable or not available, compliance will be monitored through site visit observation.

Service Characteristics

***Eligibility Screening*:** If the Food Bank/Home-Delivered Meals provider is the client's first contact with HCP, the client must be screened for eligibility as part of a formal intake, as described in the Common Standards of Care.

***Referral*:** Refer clients ineligible for Food Bank/Home-Delivered Meals services through HCP to another community-based organization or link them to another safety net provider as appropriate. Documentation of that referral must be in the client file and available upon request.

Monitoring

Referrals - Processes for referring ineligible clients to other CBOs or service providers will be monitored through discussion of these scenarios during site visits.

Orientation

Each new client enrolled in Food Bank/Home-Delivered Meals must receive an orientation to the services; document this orientation in the client file.

Monitoring

Orientation - Agencies will be asked to submit a policy related to orientation of new clients in this service category; documentation of these orientations will be monitored via site visit observation, discussion, and/or chart review.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Health Education/Risk Reduction

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Health Education/Risk Reduction" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Health Education/Risk Reduction, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes counseling and sharing information about medical and support services with clients living with HIV to improve their health status. 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., ADAP, qualified health plans through Covered California, Medi-Cal coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Key Activities

Health Education/Risk Reduction may be provided in individual and group settings. These programs should be delivered only to clients; affected individuals (partners and family members not living with HIV) are not eligible unless receiving services concurrently with the client. Health Education/Risk Reduction may NOT be delivered anonymously.

Objective

Health Education/Risk Reduction is intended to reduce HIV transmission by providing clients living with HIV with knowledge of risk factors for HIV transmission and actions they can take to reduce risk of transmission.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards for Health Education/Risk Reduction staff. All Health Education/Risk Reduction staff must be trained and knowledgeable about HIV and familiar with available HIV resources in the area. They should have good communication skills and be culturally competent.

Regardless of education/training, staff should be experienced in all of the following:

- Health education/risk reduction strategies and best practices
- HIV transmission and prevention
- Local HIV service delivery system, especially medical and support services and counseling

Individual supervision and guidance must be available to Health Education/Risk Reduction staff as needed.

Staff Orientation and Training

Initial: All staff providing Health Education/Risk Reduction must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Service Characteristics

Health Education/Risk Reduction must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

HIV education: Clients should always be provided with HIV risk reduction and prevention education, partner services information, and an overview of the HIV service delivery system including clear information on how to access those services. Clients must also be provided with counseling about how to improve their health status and reduce the risk of HIV transmission to others.

Monitoring

HIV Education - Adherence to the above standards related to HIV education and counseling content will be monitored through agency submission of materials and counseling protocols used.

Referral / Linkage: Clients should be referred for medical and support services as appropriate; documentation of that referral must be in the client file and available upon request.

Monitoring

Referral / Linkage - Existence and documentation of referrals and linkages for medical and support services will be monitored through discussion and chart review during site visits.

Partner Services: Per HCP Management Memo 15-06, HCP providers funded for Health Education/Risk Reduction must have a process for Partner Services referral and counseling for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

Partner Services - Existence of processes for Partner Services counseling and referral will be monitored through agency submission of written policies and procedures related to this topic. Implementation of the policy (i.e. that clients are actually offered and referred to Partner Services) will be monitored through observation, discussion, and/or chart review during site visits.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Hospice Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Hospice Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Hospice Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Hospice Services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness. Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board

Program Guidance

Services may be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. This service category does not extend to skilled nursing facilities or nursing homes.

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy of six months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under Medi-Cal.

Key Activities

Hospice care is intended to be palliative, rather than curative. Key activities of Hospice Services include:

- Initial assessment of the client's service needs;

- Mental health counseling, including treatment and counseling provided by mental health professionals licensed or certified in California;
- Nursing care;
- Palliative therapeutics including symptom and pain control;
- Specialized equipment and supplies for in-home hospice care;
- Physician services; and
- Room and board for residential hospice services.

Objective

Hospice Services are designed to promote the highest possible quality of life and function for clients and their families, and help terminally ill clients approach death with dignity and comfort.

Limitations

Hospice services may only be provided to clients with a physician's certification that the client has less than six months to live.

Units of Service

A Unit of Service (UOS) is a single 24-hour day of hospice services.

Requirements

Provider Qualifications

Education/Experience/Supervision

All staff will possess the appropriate and valid licensure or certification as required by the State of California to perform their duties, including:

- Physicians (including Psychiatrists)
- Physician Assistants (PA)
- Nurse Practitioners (NP)
- Psychologists
- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Licensed Clinical Social Workers (LCSW)
- Certified Nursing Assistants
- Home Health Attendants

NOTE: *Drugs and biologicals may only be administered by individuals licensed to do so.*

Individual supervision and guidance must be available to all staff as needed.

Monitoring

Provider qualifications – Availability of clinical supervision for unlicensed providers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Hospice Services must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Privacy requirements and HIPAA regulations
- Skills to provide end of life care

Ongoing: Staff must also receive ongoing annual training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Programs

Hospice programs require licensure by the California Department of Public Health and certification by Medicare.

Service Characteristics

Hospice Services must be provided in a home or other residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services. They may not be provided in a skilled nursing facility or nursing home.

Intake

To receive hospice services, clients must have received a written certification from their physician stating that they are terminally ill and have a defined life expectancy of six months or less. The hospice staff must ensure that the HCP client intake has been

performed at the start of service provision, and perform an intake if necessary. Staff should also discuss preparation of advanced medical directives (e.g., living will, durable power of attorney, Do Not Resuscitate order), and assist the client in completing any of these if desired. See the Common Standards of Care for intake requirements.

Orientation

Each new client enrolled in Hospice Services must receive an orientation to the services on admission; document this orientation in the client file.

Initial Assessment

The hospice provider must conduct a comprehensive initial assessment for services. The needs assessment will describe the client's current status and inform the needs and services plan. The assessment should include:

- Age
- Health status and comorbidities
- HIV prevention needs
- Psychological needs
- Spiritual needs
- Need for pain management/palliative care
- Current medications
- Ambulatory status
- Cognitive assessment
- Family composition and status
- Special housing needs
- Level of independence
- Available resources

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, and provision of applicable referrals/linkages, will be monitored via site visit chart review. Primary care provider certification of client's terminal status will be verified via site visit chart review.

Needs and Services Plan

Frequency: An individualized needs and services plan must be developed upon the client's admission, and re-evaluated at least every six months thereafter, as needed. Written certification from their physician stating that they are terminally ill and have a defined life expectancy of six months or less must be signed again at six months.

Requirements: Hospice providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input – including a client's right to refuse aspects of this service
- Only includes allowable activities
- Includes a statement of the problems or symptoms
- Details expected duration of services
- Ensures coordination of care, through collaboration with the client's service providers (medical provider, case manager, mental health specialist, spiritual advisor, etc.)
- Is signed and dated by the hospice provider, unless documented via the Care Plan in ARIES

Service Provision

Services should be provided utilizing methodologies appropriate for the client's needs. This may include any combination of:

Counseling Services: Counseling services that are consistent with the definition of mental health counseling, including treatment and counseling by psychiatrists, psychologists, or licensed clinical social workers.

Palliative Therapies: Palliative therapeutics for symptom and pain control that are consistent with those allowed by Medi-Cal.

Supportive Services: Hospice programs should provide or coordinate supportive services such as assistance with activities of daily living, medication management, family bereavement counseling, and others as needed.

Referral / Linkage: Programs may provide referral and linkage to the full spectrum of HIV-related services.

Monitoring

Needs and Services Plans – Provision of services consistent with the client's Needs and Services Plan, along with complete documentation, will be monitored via chart review during the site visit.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Housing Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
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TABLE OF CONTENTS

Introduction

This document describes the "Housing Services" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Housing Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Note: This document pertains to the service category of Housing and does not address the additional requirements for those providing services under the Housing Plus Project.

Service Definition

HRSA Definition

Housing services provide transitional, short-term, or emergency housing assistance (including hotel/motel vouchers) to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and increase stability for clients, allowing them to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated at least every six months, to guide the client's linkage to permanent housing. Housing services also can include housing referral services; assessment, search, placement, and advocacy services; as well as payment of fees associated with these services. Providers must have written policies and procedures that indicate the percentages of a client's monthly rent they can pay through this program.

Key Activities

Allowable activities in this service category include:

- Housing that provides some type of core medical or support services, such as:
    - Residential substance use disorder services
    - Residential mental health services
    - Residential foster care
    - Assisted living residential services

- Housing that does not provide direct core medical or support services, but is essential for a client or family to initiate or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. This includes paying or supplementing rent. In some cases this can include hotel/motel vouchers, when done on a limited basis as part of an overall plan to transition the client to permanent housing.
- Housing referral services to other (non-HCP) housing programs

NOTE: Utilities, including firewood, may be paid for under the Emergency Financial Assistance service category, but are not allowable in this service category.

Unallowable Activities

Housing services **may not:**

- Be used for mortgage payments
- Be in the form of direct cash payments to clients
- Be used for rental or security deposits. Such deposits are typically returned to clients as cash which would violate the prohibition on providing cash payments to clients.

Monitoring

Allowable Activities - Appropriateness of HCP-funded housing services (i.e. housing is essential for getting or maintaining HIV care and treatment and/or provides medical or supportive services to people living with HIV) will be monitored through chart review during site visits.

Objective

Housing Services are intended to maintain a client's housing stability, improving their ability to maintain or access medical care.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no minimum educational standards for Housing staff. Housing-related referrals must be provided by persons who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.

Individual supervision and guidance must be available to all staff as needed.

Staff Orientation and Training

Initial: All staff providing Housing Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Local housing resources including HOPWA
- Privacy requirements
- Navigation of the local HIV system of care including ADAP

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar, and must be clearly documented and tracked for monitoring purposes.

Monitoring

Provider Qualifications and Training - Agencies must maintain a comprehensive list of staff with hire date, all trainings provided (including those that are housing specific), and dates of trainings; this list must be available for review during site visits. Individual supervision and clinical guidance available to staff will be monitored through direct observation and discussions during site visits.

Service Characteristics

Eligibility Screening: If the Housing Services provider is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Newly Identified Clients: Housing Services providers should work with other HCP providers to ensure that newly-diagnosed clients and clients new to the HCP system are evaluated for and provided with Housing Services as needed.

Appointments: Initial Housing Services appointments should be made as soon as possible to avoid housing disruptions. Appointments must occur no later than 10 calendar days after the first client referral, which can be a self-referral. Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after a request. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented in the file.

Monitoring

Tracking of Appointments - Evaluation of suitability for Housing Services for clients newly-diagnosed with HIV, as well as timely provision of such services when warranted, will be monitored via discussion and/or chart review during site visits. When housing is not readily available, appointments and follow-up processes must still be in place to ensure suitable shelter is identified. Processes will be reviewed during site visits.

Duration: Services are intended to be temporary in nature. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24 months if necessary based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline. The HCP Advisor must be made aware of such an instance.

Documentation: All client contacts, as well as services, referrals, and other assistance provided to clients in order to help them obtain housing must be recorded in the client chart.

- If the client is not placed in housing that also provides some type of core medical or support services, the necessity of housing services to support treatment plan adherence must be documented.
- Documentation must include confirmed appointments to HIV-associated medical care, whether provided through their housing services provider or externally

Monitoring

Duration- Durations of service will be monitored via ARIES

Documentation - Documentation of medical necessity will be monitored through chart review.

Intake

The Housing Services provider must ensure that the client intake has been performed prior to HCP service provision and if not, perform an intake. See the Common Standards of Care for detailed intake requirements. Providers should ensure that any consents specific to housing are completed and in the client's file.

Orientation

Each new client receiving Housing Services must receive an orientation to provided services; document this orientation in the client file.

Monitoring

Orientation - Agencies will be asked to submit a policy related to orientation of new clients in this service category; documentation of these orientations will be monitored via site visit observation, discussion, and/or chart review.

Housing Plan

Housing Service providers should create an individualized housing plan for each client. The plan must include:

- Assess current housing needs
- Incorporate client input
- Guide the client's linkage to permanent housing
- Include any referrals and linkages to other needed services
- Be signed and dated by staff providing Housing Services

Reassessment

The client's housing plan must be updated at least every six months.

Monitoring

Reassessments - Individualized housing plans, including inclusion of all required content and updating at least once every six months, will be monitored via chart review during site visits.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Linguistic Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Linguistic Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Linguistic Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Linguistic Services provide interpretation and translation services to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of other HCP services.

Program Guidance

Linguistic Services are intended to facilitate effective communication between clients and providers of HCP or other HIV-related services, and to improve service delivery. Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS): https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.

Key Activities

Key activities of Linguistic Services include:

- Oral interpretation of conversations between clients and providers in the client's preferred language, and
- Written translation of documents to the client's preferred language whenever possible, including posted materials relevant to HIV services. When an agency does not have capacity to translate written materials to a language not typically spoken in their jurisdiction, oral translation of these documents may be provided instead.

Linguistic services may be provided in group or individual settings; funds may also be used to pay for translating printed materials. Interpretation services may be provided by language lines.

Objective

The goal of Linguistic Services is to ensure that clients with a preferred language other than English are able to effectively communicate with providers.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a translator, interpreter, or other provider of Linguistic Services, whether by phone or face-to-face. When Linguistic Services are used during the course of providing other HCP-funded services (such as Medical Case Management), both services should be entered into ARIES. However, if a provider is bilingual and is providing typical services in a preferred language other than English, the service should be billed under the relevant service category, and Linguistic Services may not also be billed.

Requirements

Provider Qualifications

Education / Experience / Supervision

All services must be provided by trained and qualified individuals holding appropriate American Translators Association certification, State of California Court Interpreter certification, or local certification. Providers may utilize commercial interpretation services if existing staff are unable to perform these functions.

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Provider qualifications – Assurance that all services provided are commensurate with the training, education, and licensure/certification must be kept in personnel files, with hire date for review during site.

Staff supervision – Availability of individual supervision for interpreters and translators will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Linguistic Services within an agency funded by HCP must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including continuing education required locally or by the State of California to maintain certification where applicable. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Service Characteristics

Treatment Provision: Linguistic Services must be provided whenever necessary to ensure effective communication between the provider and the client. Clients should be notified of the availability of translation and interpretation services at intake/orientation and as appropriate. Other best practices include the use of signage explaining the availability of Linguistic Services in multiple languages as appropriate for the site.

Documentation: All client contacts and other information pertinent to services must be recorded in the client chart and documented in ARIES.

Monitoring

Documentation – Provision of linguistic services, including languages available and utilized, will be monitored during site visits via chart review.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Medical Case Management
(including treatment adherence)

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the Medical Case Management service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Medical Case Management, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Tools and Resources.

Service Definition

HRSA Definition

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be delivered by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key Activities

Key activities of Medical Case Management include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a medical case manager;
- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan at the initial assessment, including client-centered goals and milestones;
- Timely and coordinated access to medically appropriate levels of healthcare and support services;
- Routine client monitoring to determine the efficacy of the care plan;
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems;

- Treatment adherence counseling to ensure that the client is ready for and adheres to HIV treatments;
- Client-specific advocacy and/or review of service utilization as appropriate; and
- Benefits counseling whereby staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, Housing Opportunities for Persons with AIDS (HOPWA), and/or other state or local health care and supportive services).

Objective

Medical Case Management services are designed to improve health care outcomes for clients, whereas Non-Medical Case Management Services provide guidance and assistance to improve access to needed services.

Priority Populations

Populations that should be prioritized for Medical Case Management include those who are newly diagnosed with HIV, homeless or unstably housed, recently released from incarceration, pregnant women, youth ages 18-24, or others with high acuity.

Monitoring

Priority Populations - Prioritization of high-acuity/high-need patients will be monitored through site visit chart review, and HCP review of acuity assessments and related written policies and procedures.

Requirements

Provider Qualifications

Education / Experience / Supervision

The minimum educational requirements for a Medical Case Manager include 1) any health or human services bachelor's degree from an accredited college or university or 2) certificate/licensure in any of the following categories:

- Physician's Assistant (PA)
- Nurse Practitioner (NP)
- Public Health Nurse (PHN)

- Registered Nurse (RN)
- Social Work
- Counseling
- Psychology
- Gerontology
- Clinical Pharmacy

Medical Case Managers who do not meet this minimum educational requirement may substitute related direct consumer service experience under the supervision of a health or human services professional for a period of three (3) years of full-time work.

Contractors may choose to require additional education or licensure for Medical Case Managers, especially those in supervisory roles.

Medical Case Managers without a valid certification or license in their field must receive clinical oversight and support by meeting with a licensed clinician monthly or more frequently for urgent situations.

Monitoring

Education/Experience/Supervision - Credentialing and/or other education or experience meeting the minimum requirements for service provision in this category must be kept in personnel files, with hire date. Availability of clinical supervision for unlicensed medical case managers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Medical Case Management Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Privacy requirements
- Navigation of the local HIV system of care including ADAP and HOPWA
- Basic case management skills

Other topics may include:

- Motivational Interviewing
- Trauma Informed Care

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar

Monitoring

Staff Training - All trainings provided, and dates of trainings must be available for review during site visits or upon request.

Caseload

Medical Case Managers are expected to maintain a caseload of between 40 and 65 clients at any given time depending on the acuity of clients.

Monitoring

Caseload - Agencies must submit to HCP their written policies and procedures for caseload review and redistribution when warranted, to adhere to caseload standards.

Service Characteristics

Medical Case Management must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. All Medical Case Management services must include, at a minimum, the Key Activities included in the ***Service Definition*** section of this document. Other key characteristics include:

Eligibility Screening: If the Medical Case Manager is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Initial Medical Case Management Appointments: Initial Medical Case Management appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days after first client referral which can include self-referral. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and case management attempts at rescheduling must be documented in the file.

Monitoring

Initial Appointment - Timeframe for intake appointments for new clients will be monitored through chart review. Agencies will be asked to submit to HCP written policies and procedures for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Referral: Clients ineligible for Medical Case Management services through HCP must be referred to another community-based organization or safety net provider utilizing a warm handoff when possible. Documentation of that referral must be in the client file and available upon request.

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Monitoring

Referrals - Documentation of referral of ineligible clients to other services will be monitored via chart review during site visits.

Primary Case Manager: Each client should always have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager will serve as the main point person for the client to streamline communication and maximize care coordination.

Monitoring

Primary Case Manager - Review of primary case manager assignment will be conducted during chart review.

Partner Services: Per HCP Management Memo 15-06, HCP providers funded for Medical Case Management must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

Partner Services - Existence of processes for Partner Services counseling and referral will be monitored through agency submission of written policies and procedures related to this topic. Implementation of the policy (i.e. that clients are actually offered and referred to Partner Services) will be monitored through observation, discussion, and/or chart review during site visits.

Intake

The Medical Case Manager must ensure that the client intake has been performed at the start of service provision and perform an intake if one has not previously been completed. See the Common Standards of Care for detailed intake requirements.

Orientation

Each new client enrolled in Medical Case Management must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment

The Medical Case Manager must conduct a comprehensive face-to-face psychosocial needs assessment within 30 days of the start of Medical Case Management Services. The needs assessment will describe the client's current status and identify their strengths and weaknesses, resources, and/or stressors in order to develop a relevant treatment plan which allows the patient to function and manage their condition as independently as possible. This assessment must be thoroughly documented, and should be client-centered (the client may defer or choose not to discuss any specific issues during the assessment). Topics for discussion during the assessment should include:

- Primary care connection;
- Connection with other care providers (e.g. dentist, specialists, key social services)
- Current health status / medical history, including last and next medical appointment, most recent CD4 and VL, and any reasons for terminating care (if applicable);
- Oral health and vision needs
- Current medications / adherence;
- Immediate health concerns;
- Substance use history;
- Mental health / psychiatric history;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Treatment adherence history, including assessment of ability to be retained in care;
- Self-management skills and history;
- Prevention and risk reduction issues;
- History of incarceration
- Family composition;
- Living situation;
- Languages spoken;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Transportation needs;
- Legal issues
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Nutritional status assessment;
- Partner Services needs;
- Cultural issues, including ethnic, spiritual, etc.; and
- Summary of unmet needs.

Monitoring

Initial Assessment - Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkages, will be monitored via site visit chart review.

Development of Care Plan

Existing Care Plan: When an existing care plan is present (e.g., if the client has received other HCP services), that care plan should be reviewed and utilized in the creation of the Medical Case Management care plan.

Frequency: An individualized care plan must be developed during the initial assessment, and re-evaluated at least every 6 months with modifications as needed.

Requirements: Medical Case Managers developing an individualized care plan should ensure that the plan, at a minimum:

- Is individualized and medically-focused
- Incorporates client input
- Sets realistic goals, objectives, and timelines based on client needs identified by the client and medical team. The goals must be measurable and identify who is responsible for each intervention
- Identifies resources to attain the goals and objectives, including collaboration with other relevant providers (e.g. substance abuse counselors, physicians, housing specialists)

The Medical Case Manager may also develop a "compliance contract" if preferred by the client. The written care plan/compliance contract should be signed by the client and a copy should be provided to the client.

Updates: As the client's status changes, the client and case manager must work together to establish new goals, objectives, and timelines.

Documentation: Care plans can be documented in paper charts, EMR, or in ARIES under the "Care Plan" tab. Copies of completed individualized care plans must be uploaded to ARIES and/or retained in the client file, signed by both client and provider if paper based. Client and provider must also sign any updated plans if paper based.

Monitoring

Care Plans - Development of individualized, medically-focused care plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits. Care plans may be uploaded to ARIES; however, this is not required. Documentation of care plan development per ARIES will be reconciled with the existence of care plans in patient charts during site visits, as applicable.

Quality Assurance and Supervision: All agencies providing Medical Case Management must have a quality assurance plan in place describing a supervisory review to assess

documentation of client's needs and if those needs were addressed. Annually, a representative sample of at least 10 percent of charts of active Medical Case Management clients must have a supervisor review. All clients who are discharged from Medical Case Management must also have a supervisor review within 3 months of discharge. Supervisors' reviews must be documented in the client chart with signature, date of review, and findings. If staff supervisors are not licensed providers, the agency must have a review process by a licensed provider that meets the above requirements. Licensed providers may not perform the review of their own clients' charts.

Monitoring

Chart Reviews - Annual review of client charts by clinical providers will be monitored via chart review during site visits.

Coordination of Services

Client Record: All Medical Case Management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record as soon as possible and entered into ARIES within two (2) weeks. Documentation of activities must be legible, signed, and dated by the Medical Case Manager.

Case Conferencing: Formal case conferences must be held at least once per quarter for all clients to coordinate care among providers from different services, fields, and disciplines. For clients experiencing significant changes or unexpected absence from care, more frequent case conferences may be necessary. Case conferencing should be done through a formal meeting with a multidisciplinary team that is appropriate to the needs of the client. Memoranda of Understanding (MOUs), Releases of Information, or other standardized agreements may be necessary to ensure participation in the multidisciplinary team by all necessary staff.

- **Discussion:** During case conferencing, a review of the care plan and an evaluation of the services the client is receiving should be performed, as well as discussion of the client's current status (coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.).
- **Client Input:** The client and/or their legal representative must be given the opportunity to provide input to the Medical Case Manager about their care plan for discussion at the case conference.
- **Documentation:** Appropriate documentation must also be kept in the client chart or record including:
    - Names and titles of those attending the case conference,
    - Key information discussed, and

- Whether the client or legal representative had input into the conference and the outcomes.

- Documentation of the case conferencing can be captured in ARIES by entering the service Medical Case Management with the subservice of Case Conferencing.

Monitoring

Case Conferencing – Documentation of quarterly case conferencing in client charts (including use of a multidisciplinary team, opportunity for client/caregiver/legal representative input) will be monitored via chart review during site visits.

Client Monitoring

Follow-Up and Monitoring. Medical Case Management is an ongoing management process, not simply initial or occasional assessments and referrals. Individuals who are self-sufficient and do not need periodic follow-up related to their medical care or treatment adherence may not need Medical Case Management services, and may be discharged and referred to Non-Medical Case Management services as needed (see *Client Transfer and Graduation*, below). Medical Case Management shall target individuals needing support in accessing and maintaining regular care in order to improve their health outcomes. Follow-up contact by Medical Case Managers shall be appropriate to the needs of the client, but contact should be made on at least a monthly basis to prevent clients from falling out of care. To that end:

- Medical Case Managers shall respond in a timely and appropriate manner to client requests for assistance and to client needs identified by other providers. In general, case managers are expected to respond to clients and providers within one working day.
- Even when a Medical Case Manager has not become aware of any care-related problems or situational issues, they shall contact the client periodically in case the client has hesitated to contact the case manager about their needs or issues regarding services. Such contacts can serve as opportunities for reassessment of the client's needs and living situation. Frequency of these contacts shall be determined by the case manager's assessment of the client's situation.
- For newly diagnosed clients, Medical Case Managers should meet more frequently during the initial intake process in order to ensure clients are linked to HIV-related medical care within 30 days, at the latest. Ideally, linkage to care occurs within 24 hours of diagnosis.

Lost to Follow-up. The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts

to contact the client must take place on different days and times of the day during this time period. Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities. See the *Client Transfer and Case Closure* section of this document.

Monitoring

Client Contact - Frequency of client contact by medical case managers (i.e. at least once monthly) will be monitored through review of services in ARIES.

Reassessment/Revision of Care Plan

Medical Case Managers should routinely review the successes and challenges clients are having in achieving outcomes as outlined in the service plan, measure progress in meeting goals and objectives, and revise the plan as necessary.

Revision of care plan: Client assessment and revision to the care plan as appropriate must be made at least every 6 months or more frequently as client condition changes.

Documentation: Medical Case Managers must routinely document the outcome of reassessments and service activities in the client record, ARIES, client contact form, and outcome log (if applicable).

Feedback: Medical Case Managers must provide constructive feedback to clients when reviewing the care plan and progress made toward goals and objectives. Constructive feedback is based on concrete observations, and is focused on providing information to the client in a non-judgmental way. Feedback should be strengths-based whenever possible.

Monitoring

Reassessment/Revision of Care Plan - Documentation of care plan reassessment and revision will be monitored via review of client charts and/or electronic health records during site visits; timing and quality of the reassessment (including the use of constructive feedback) will be monitored via discussion and client chart review during site visits.

Treatment Adherence Counseling

Monitor Treatment Adherence: Medical Case Managers shall monitor client treatment adherence. Client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc. are used to assist with adherence monitoring. Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client. As needed, the Medical Case Manager shall determine who has the primary responsibility for giving

medication, and shall provide HIV and adherence education to family members or caregivers as applicable. Medical Case Managers shall refer clients to additional treatment adherence services as needed.

To support treatment adherence, Medical Case Managers shall:

- Make an effort to identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)
- Communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed.
- Consult the client's current laboratory results regularly for monitoring purposes

Advocacy and Utilization Review

Medical Case Managers must ensure the provision of a basic needs assessment and assistance (through appropriate referrals) in obtaining medical, social, community, legal, financial, and other needed services. Key activities include:

- Assessment of service needs
- Provision of information and/or referrals; referrals should involve a warm handoff whenever possible
- Assistance in obtaining official documentation such as an ID, if needed
- Clear documentation of assessment and referrals

Client Transfer and Case Closure

Transfer of Clients: In the event that a client wishes to (or needs to) transition to Medical Case Management services offered by another agency, relevant intake documents should be forwarded to the new service provider after obtaining a release of information from the client. Case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained. Transfer of clients between agencies or case managers is initiated when:

- The client notifies the case manager that they have moved to a different service area,
- The client notifies the case manager of their intent to transfer services to another agency,
- The Forced Disenrollment Grievance Procedure has been followed as defined in the Common Standards of Care, or
- The agency no longer receives funding.

Case Closure: Discharge from Medical Case Management services may affect the client's ability to receive and stay compliant with medical care. As such, discharge from Medical Case Management must be carefully considered with reasonable steps taken to ensure clients who need assistance in accessing care are maintained in case management programs. Agencies should close a client's file according to the written procedures established by the agency, as well as those outlined in the Common Standards of Care. A client file may be closed under any of the conditions listed in the Common Standards of Care. Additional circumstances for closing a Medical Case Management case include:

- The client no longer demonstrates need for Medical Case Management due to their own ability to effectively advocate for their needs
    - Agencies must have written policies and procedures to "graduate" clients out of Medical Case Management (and into other services if appropriate, such as Non-Medical Case Management) including specific criteria for determining that the client is ready to graduate.
- A client is being incarcerated for more than 6 months and adequate care exists within the correctional setting
    - If a client's incarceration is for a period of 6 months or less, the Medical Case Manager should coordinate services with correctional medical staff in order to ensure continuity of care upon release.
- The client is transitioning into Medical Case Management services offered by another agency, as described above

Tools and Resources

More information about Medical Case Management can be found here:

TARGET Center resources on Medical Case Management:
https://careacttarget.org/category/topics/case-management

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Medical Nutrition Therapy

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Medical Nutrition Therapy" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Medical Nutrition Therapy, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Medical Nutrition Therapy, including nutritional supplements, is provided by a licensed, registered dietitian outside of an Outpatient/Ambulatory Health Services visit. Food may be provided pursuant to the recommendation of a health care professional (i.e., physician, physician assistant, nurse practitioner) with a nutritional plan developed by a licensed, registered dietician. Nutritional counseling services and nutritional supplements not provided by a licensed, registered dietician shall be considered a support service and be reported under Psychosocial Support Services and Food Bank/Home-Delivered Meals, respectively. Food not provided pursuant to a health care professional's recommendation and nutritional plan developed by a licensed, registered dietician should also be considered a support service and is reported under Food Bank/Home Delivered Meals.

Program Guidance

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

Key Activities

Key activities of Medical Nutrition Therapy include:

- Nutrition assessment and screening;
- Dietary/nutritional evaluation and development of a nutritional plan at the first visit;
- Food and/or nutritional supplements per medical provider's recommendation; and
- Nutrition education and/or counseling.

Medical Nutrition Therapy services can be provided in individual and/or group settings outside of Outpatient/Ambulatory Health Services visit.

Objective

The objective of Medical Nutrition Therapy is to optimize the nutritional status of clients by preventing dietary deficiencies, and promote the maintenance of healthy weight and body composition in order to maximize effectiveness of antiretroviral treatment and overall health.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a registered dietitian (RD) for medical nutrition therapy, nutritional counseling, or the development of a nutritional plan, or a single transaction for the client to receive nutritional supplements.

Requirements

Provider Qualifications

Education / Experience / Supervision

Medical Nutrition Therapy services are provided by dietitians licensed and registered in the State of California. Providers should be trained and knowledgeable in HIV-related issues. Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Provider qualifications – Staff experience meeting the minimum requirements for service provision in this category must be kept in personnel files, with hire date for review during site visits.

Supervision and guidance – Provision of routine supervision and guidance will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Medical Nutrition Therapy must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including any continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Service Characteristics

Medical Nutrition Therapy must be offered in a way that addresses barriers to accessing nutritional care and uses resources to support positive health outcomes for clients. All Medical Nutrition Therapy must include the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Initial Medical Nutrition Therapy Appointments: Initial Medical Nutrition Therapy appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 30 calendar days after the first client referral, but should be scheduled sooner whenever possible. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the client file.

Monitoring

Appointment scheduling and follow-up – In advance of site visits, agencies will be asked to submit to HCP written policies for initial appointment scheduling and client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Orientation

Each new client enrolled in Medical Nutrition Therapy must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment

The Medical Nutrition Therapy provider must conduct a comprehensive face-to-face assessment within 30 days of referral. The nutritional assessment will describe the client's current status and inform the nutritional plan. The nutritional assessment should include:

- Baseline body weight
- Medical history, including current medications, immunity, overall well-being, and any complications or other medical problems (i.e., diabetes, cardiovascular, kidney and liver diseases)

- Assessment of the client's nutritional status using a validated tool, such as the HIV/AIDS Evidence-based Toolkit from the Academy of Nutrition and Dietetics.
- Documentation of a physician's recommendation if food or nutritional supplements are to be provided

Documentation: All client contacts, findings, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, will be monitored via site visit chart review.

Nutritional Plan

Frequency: An individualized treatment plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed.

Requirements: Medical Nutrition Therapy providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Identifies and prioritizes the client's nutritional needs
- Includes a statement of the problems to be addressed in treatment
- Recommended services and course of medical nutrition therapy to be provided, including types and amounts of nutritional supplements and food
- Notes the date service is to be initiated
- Details frequency and expected duration of services
- Notes any nutritional supplements and/or food provided, including the quantity and date
- Is signed and dated by the provider unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the ARIES record)

Treatment Provision: Medical Nutrition Therapy should be provided in a way that is consistent with the nutritional plan. All services including supplements or food provided should be documented in the client's chart.

Monitoring

Nutritional Plans – Presence of a written nutrition plan outlining each client's needs and progress and documentation of services provided including any supplements and/or food provided, will be monitored via site visit chart review.

Reassessment

The nutritional plan should be reviewed at each appointment, and revised when indicated or at least every six months.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Medical Transportation

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Medical Transportation" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Medical Transportation Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

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

Key Activities

Medical Transportation services may be provided through:

- **Contracts with providers** of transportation services
- **Voucher or token** systems for ride-limited vouchers (i.e. not monthly unlimited passes) except in cases where it can be demonstrated that a monthly pass would be more cost-effective to enable access to medical and support services
- **Mileage reimbursement** (through a non-cash system, e.g. gas cards, etc.) that enables clients to travel to needed medical or other support services
    - Reimbursement should NOT exceed the established rates for federal programs (Federal Travel Regulations provide further guidance on this subject)
- **Purchase or lease of organizational vehicles** for client transportation programs
    - The recipient must receive prior approval from OA and HRSA for the purchase of a vehicle
- Organization and use of volunteer drivers
    - Programs must specifically address insurance and other liability issues

Costs for transportation for providers or case managers to provide care should be categorized under the service being provided.

Unallowable Activities

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Monthly unlimited public transportation passes, except in cases where it can be demonstrated and a necessary and more cost-effective option
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Monitoring

Unallowable Cost - Verification that funds are being used only for allowable costs will be conducted via submission of budgets and invoices, and HCP desk audit of services.

Fiscal Management

There are additional requirements when utilizing vouchers, gas cards, taxi tokens, or bus tickets or passes.

- Providers must ensure that vouchers or store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services.
- General-use prepaid cards are considered equivalent to cash and are therefore unallowable. Such cards generally bear the logo of a payment network (e.g., Visa, MasterCard, or American Express) and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
- Providers must have systems in place to account for disbursed vouchers. The systems must track: client's name, staff person who distributed the voucher, date of the disbursement, voucher dollar amount, voucher serial number, and confirmation that the client went to their medical or support services appointment. These data elements can be tracked on the ARIES Services screen if no other tracking system is available.
- Providers should only buy vouchers in amounts that are reasonable for use in the contract year. In no case should use of vouchers lead to monies being held over to future contract years.

Monitoring

Fiscal Management - Management of vouchers per the bullet points above will be monitored through agency submission of written policies and procedures for accounting of disbursed vouchers, desk audit of submitted budgets and invoices related to purchase of specific types of vouchers or gift cards, and site visit verification of the use of these products.

Objective

Medical Transportation Services are intended to remove transportation barriers preventing clients from accessing necessary HIV-related health and support services.

Requirements

Provider Qualifications

Medical Transportation Services may be provided directly by provider staff or volunteers, by staff of an outside company/agency (i.e., taxi service, ride share such as Lyft, paratransit), or by individuals such as family or friends.

Education / Experience / Supervision

There are no minimum educational standards. Agency staff providing medical transportation must:

- Have a valid California Driver's License with any endorsements required by California law (e.g., passenger endorsement if driving vehicles designed for >10 passengers)
- Hold the minimum required amount of automobile insurance as required by law, and be enrolled in the Employer Pull Notice program and affiliated with the agency's requester code.

Monitoring

Qualifications - Existence of valid California Driver's Licenses, minimum automobile insurance, and proper enrollment in the Employer Pull Notice program will be monitored through personnel file review during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Medical Transportation Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, including HIV transmission
- Universal precautions

- Privacy requirements

Additional: Staff who directly provide Medical Transportation Services must also receive initial and ongoing safety training as appropriate for their position and required by federal, state, or local regulations. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes. Topics must include:

- Emergency equipment
- Defensive driving
- Cardiopulmonary Resuscitation (CPR) and first aid (renewed every two years)
- Pre-trip inspections

Vehicles

Any agency or staff vehicles used for client transportation must be registered, insured, and in safe operating condition. They must be equipped with seat belts and other safety equipment as appropriate.

- **Children:** If children are transported, child safety seats must be provided and all staff and volunteers transporting children must be trained on how to properly install and use the seat. Seat type, installation, and use must comply with California state law.
- **Disabled clients:** Disabled clients must be transported in Americans with Disability Act (ADA)-compliant vehicles, and all staff and volunteers transporting clients with disabilities must be trained on how to properly and safely transport these clients.

Monitoring

Vehicles - Appropriate registration and safety of vehicles, as well as presence of child safety seats or ADA-compliant equipment and written policies and procedures when applicable, will be monitored through direct observation during site visits.

Service Characteristics

Intake

The Medical Transportation provider must ensure that the client intake has been performed at the start of service provision, and if it has not perform an intake if necessary. See the Common Standards of Care for intake requirements.

Medical Transportation Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

Medical Transportation Services providers may provide any or all of the activities included in the ***Service Definition*** section of this document.

Contracts: Transportation services may be provided via contract or other local procurement mechanism that directly compensates the provider, including ride share, taxi, or van services.

Vouchers/Tokens: Clients may be provided with vouchers or tokens for use on public transportation systems. The vouchers or tokens must be trackable through serial number or other method. Clients may NOT be provided with cash payments for public transportation.

Mileage Reimbursement: Clients using their own vehicle to access HIV-related medical or support services may receive gas vouchers to help defray the cost. Clients must keep a record of trips to be reimbursed, including mileage and purpose. Reimbursement may NOT be provided by cash (or equivalent), nor exceed the established rates for federal programs as described in the Federal Travel Regulations. The following expenses are not eligible for reimbursement:

- Parking
- Tires, vehicle maintenance, or repairs
- Lease or loan payments
- Insurance
- License or registration fees

Monitoring

Documentation - All clients served by HCP-funded Medical Transportation must be entered in ARIES; necessity of services will be monitored via chart review during site visits. Provision of benefits through direct provider compensation (i.e. service contracts, etc.) or vouchers/tokens must adhere to above standards and be appropriately documented in agency records and/or client charts, available for review upon request.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Mental Health Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Mental Health Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Mental Health Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Mental health services are outpatient psychological and psychiatric treatment and counseling services for individuals living with HIV who have mental illness. They are conducted in an outpatient group, couple/family, or individual setting and provided by a mental health professional licensed or authorized within California to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. **Services such as support groups provided by non-mental health professionals** should be reported under Psychosocial Support Services.

Key Activities

Key activities of Mental Health Services include:

- Initial assessment of the client's service needs;
- Development of a comprehensive, individualized treatment plan, including client-centered goals and milestones;
- Treatment provision in individual, family, and/or group settings, crisis intervention, and psychiatric consultation;
- Referral/coordination/linkages with other providers to ensure integration of services and better client care;
- Re-assessment and re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary; and
- Development of follow-up plans.

Objective

Mental health services are designed to assist clients in coping with the emotional and psychological aspects of living with HIV, improve psychological well-being, and increase quality of life through counseling and adherence to medical care.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a Mental Health Services provider, or a 15-minute action by a provider on behalf of a client.

Requirements

Provider Qualifications

Education / Experience / Supervision

Professional diagnostic and therapeutic services under this service category must be provided by practitioners holding appropriate, current, and valid California licensure or certification, including:

- Psychiatrists
- Psychologists
- Psychiatric Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)

Monitoring

Provider qualifications – Proof of compliance with minimum qualifications for all providers offering diagnostic and therapeutic services must be kept in personnel files, with hire date for review during site visits.

Other professional and non-professional ("waivered") staff may provide services appropriate for their level of training/education as part of a care team under the supervision of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Non-professional staff include but are not limited to:

- Peer Navigators
- Community Health Workers
- Trainees

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Supervision and guidance by a clinician – Availability of supervision and guidance by a clinician for unlicensed providers will be monitored via discussion during site visits. Assurance that all services provided are commensurate with the training and education of providers will be verified through in-person chart review during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Mental Health Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Ongoing: Staff must also receive ongoing annual training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Legal and Ethical Obligations

Practitioners must be aware of and able to practice according to California state law and the code of ethics of their respective professional organizations. Obligations include the following:

- **Duty to treat:** Practitioners may not refuse treatment to a person in need because of fear or disapproval of someone's behavior, identity, or health status, including HIV.

- **Confidentiality:** Practitioners must maintain client confidentiality. Limits of confidentiality include danger to self or others, grave disability, child/elder abuse and, in some cases, domestic violence.
- **Duty to warn:** Serious threats of violence against a reasonably identifiable victim must be reported. At present, California law does not consider a person with HIV engaging in behaviors that may put others at risk for HIV a circumstance that warrants breaking confidentiality.

Service Characteristics

Mental Health Services must be offered in a way that addresses barriers to accessing mental health care and uses resources to support positive health outcomes for clients. Clients who otherwise qualify for RWHAP Part B services may not be denied services on the basis of current substance use. All Mental Health Services must include the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Initial Appointments: Initial Mental Health Services appointments should be made as soon as possible to avoid potential drop out. Initial intake appointments should occur within 10 days of first referral to assess immediate needs; full assessments must occur no later than 30 calendar days after first client referral and should be scheduled sooner whenever possible. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Emergency Appointments: Clients in crisis must be provided with Mental Health Services immediately or as soon as possible; regular intake and assessment procedures may be followed after the initial crisis has resolved.

Monitoring

Appointment scheduling and follow-up – Agencies will be asked to submit to HCP policies for emergency appointments and client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Orientation

Each new client enrolled in Mental Health Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment

The mental health care provider must conduct a comprehensive face-to-face mental health needs assessment within 30 days of referral. The needs assessment will describe the client's current status and inform the treatment plan. The mental health assessment should include:

- A detailed statement of the client's current presenting problem
- A detailed mental health treatment history, including psychotropic medications
- Substance use history
- Mental status exam (MSE)
- All relevant Diagnostic and Statistical Manual of Mental Disorders (DSM-V) diagnoses

Referral / Linkage: Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, existence of a comprehensive diagnostic evaluation, and provision of applicable referrals/linkages will be monitored via site visit chart review.

Treatment Plan

Frequency: An individualized treatment plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed.

Requirements: Mental health providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Identifies and prioritizes the client's mental health care needs
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment
- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and mental health team
- Identifies interventions, modalities, and resources to attain the goals and objectives, including referral and linkage to other relevant providers (e.g., substance abuse counselors, physicians, housing specialists)
- Details frequency and expected duration of services
- Is signed and dated by the provider unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the record)

The treatment plan should be reviewed and revised at each appointment as needed.

Treatment Provision

Services should be provided utilizing methodologies appropriate for the client's needs and following national recommendations for HIV mental health care guidelines. This may include any combination of:

- Individual counseling/psychotherapy
- Family counseling/psychotherapy
- Couples counseling/psychotherapy
- Group psychotherapy/treatment
- Drop-in groups
- Crisis intervention
- Psychiatric medication assessment, prescription, and monitoring

Documentation: Completed individualized treatment plans must be signed and dated by a provider; "waivered" staff must obtain signature of supervising clinicians where required under California law.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Non-Medical Case Management

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Non-Medical Case Management" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Non-Medical Case Management, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Non-Medical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (OA-HIPP), Disability Insurance, Housing Opportunities for Persons With AIDS (HOPWA), Social Security, Pharmaceutical Manufacturer's patient assistance programs, Covered California, or other state or local health care and supportive services. This service category can be delivered through several methods of communication including face-to-face contact, phone contact, and any other forms of communication deemed appropriate.

Key Activities

Key activities for Non-Medical Case Management include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a non-medical case manager;
- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan during the initial assessment visit including client-centered goals and milestones;
- Ongoing client monitoring to determine the efficacy of the care plan;
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

Objective

Non-Medical Case Management Services provide guidance and assistance to improve access to needed services, whereas Medical Case Management services are designed to improve health care outcomes.

Requirements

Provider Qualifications

Education / Experience / Supervision

The educational requirements for a Non-Medical Case Manager include any health or human services bachelor's degree from an accredited college or university. Licensure is not required. Examples of health or human services fields include, but are not limited to:

- Nursing
- Social Work
- Counseling
- Psychology
- Gerontology
- Clinical Pharmacy

Non-Medical Case Managers who do not meet this minimum educational level may substitute related direct consumer service experience under the supervision of a health and human services professional for a period of two years of full-time work, regardless of academic preparation.

All Non-Medical Case Managers must be trained and knowledgeable about HIV and familiar with available HIV resources in the area.

Monitoring

Education/Experience/Supervision - Agencies must maintain personnel files with hire date, educational qualifications or experience, these records must be available for review during site visits. Access to individual supervision and clinical guidance will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Non-Medical Case Management must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention

- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care
- Basic case management skills

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff Training - All trainings provided, and dates of trainings must be available for review during site visits or upon request.

Caseload: Non-Medical Case Managers are expected to maintain a caseload of between 30 and 75 clients at any given time depending on client acuity.

Monitoring

Caseload - Agencies must submit to HCP their written policies and procedures for caseload review and redistribution when warranted, to adhere to caseload standards.

Service Characteristics

Non-Medical Case Management must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. All Non-Medical Case Management services must include at a minimum the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Eligibility Screening: If the Non-Medical Case Manager is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Initial Non-Medical Case Management Appointments: Initial Non-Medical Case Management appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days after first client referral. As clients may miss appointments, agencies must have a process in place to ensure timely follow up, preferably within 24 hours. Missed appointments and case management attempts at rescheduling must be documented in the file.

Monitoring

Initial Appointment - Timeframe for intake appointments for new clients will be monitored through chart review. Agencies will be asked to submit to HCP written policies and procedures for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Referral/Linkage: Clients ineligible for Non-Medical Case Management services through HCP must be referred to another community-based organization or linked to another safety net provider as appropriate utilizing a warm hand off when possible. Documentation of that referral must be in the client file and available upon request.

Monitoring

Referral/Linkage - Documentation of referral of ineligible clients to other services will be monitored via chart review during site visits.

Primary Case Manager: Each client should always have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager (who may or may not be the Non-Medical Case Manager) will serve as the main point person for the client to streamline communication and maximize care coordination.

Monitoring

Primary Case Manager - Review of primary case manager assignment will be conducted during chart review.

Partner Services: Per HCP Management Memo 15-06, HCP providers funded for Non-Medical Case Management must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

Partner Services - Existence of processes for Partner Services counseling and referral will be monitored through agency submission of written policies and procedures related to this topic. Implementation of the policy (i.e. that clients are actually offered and referred to Partner Services) will be monitored through observation, discussion, and/or chart review during site visits.

Intake

The Non-Medical Case Manager must ensure that the client intake has been performed at the start of service provision and perform an intake if one has not previously been completed. See the Common Standards of Care for detailed intake requirements.

Orientation

Each new client enrolled in Non-Medical Case Management must receive an orientation to the services; document this orientation in the client file.

Initial Assessment

The Non-Medical Case Manager must conduct a face-to-face psychosocial needs assessment within 30 days of the start of Non-Medical Case Management services. The needs assessment will describe the client's current status and identify their strengths and weaknesses, resources, and/or stressors in order to develop a care plan which allows the patient to function and manage their condition as independently as possible. This assessment must be thoroughly documented and should be client-centered (the client may defer or choose not to discuss any specific issues during the assessment). Topics for discussion during the assessment should include:

- Current healthcare and social service providers (including Case Management offered elsewhere);
- Level of engagement in health care services;
- Current medications and adherence;
- Immediate health concerns;
- Substance use history and needs;
- Mental health / psychiatric history and needs;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Self-management skills and history;
- History of incarceration;
- Family composition;
- Living situation and housing needs;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Food/clothing needs;
- Transportation needs;
- Legal needs;
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Partner services needs; and
- Summary of unmet needs.

Monitoring

Initial Assessment - Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkages, will be monitored via site visit chart review.

Development of Care Plan

Existing Care Plan: When an existing care plan is present (e.g., if the client has received other HCP services), that care plan should be reviewed and utilized in the creation of the Non-Medical Case Management care plan. The Non-Medical Case Management care plan should be made available to other providers as needed for care coordination.

Frequency: An individualized care plan must be developed during the initial assessment and re-evaluated at least every 6 months with modifications as needed.

Requirements: Non-Medical Case Managers developing an individualized care plan should ensure that the plan, at a minimum:

- Is individualized and incorporates client input;
- Prioritizes the needs identified in the Initial Assessment;
- Identifies resources to meet the needs identified in the Initial Assessment and provides referrals to other relevant providers (e.g. substance abuse counselors, physicians, housing specialists);
- Includes specific measurable goals and objectives with activities and timeframes to meet each objective; and
- Encourages a client's active participation and empowers the client to become self-sufficient.

Clients with significant unmet medical needs should be referred to Medical Case Management for additional support in improving health outcomes.

Updates: As the client's status changes, the client and case manager must work together to establish new goals, objectives, and timelines.

Documentation: Care plans can be documented in paper charts, EMR, or in ARIES under the "Care Plan" tab. Copies of completed individualized care plans must be uploaded to ARIES and/or retained in the client file, signed by both client and provider if paper based. Client and provider must also sign any updated plans if paper based.

Quality Assurance and Supervision: All agencies providing Non-Medical Case Management must have a quality assurance plan in place describing a supervisory review to assess documentation of client's needs and if those needs were addressed. Annually, a representative sample of at least 10 percent of charts of active Non-Medical Case Management clients must have a supervisor review. All clients who are discharged from Non-Medical Case Management must also have a supervisor review within 3 months of discharge. Supervisors' reviews must be documented in the client chart with signature, date of review, and findings.

Client Record: All Non-Medical Case Management activities including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record as soon as possible and entered into ARIES within two (2) weeks. Documentation of activities must be legible, signed, and dated by the Non-Medical Case Manager.

Monitoring

Care Plan - Development of individualized care plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits. Care plans may be uploaded to ARIES; however, this is not required. Documentation of care plan development per ARIES will be reconciled with the existence of care plans in patient charts during site visits, as applicable.

Client Monitoring

Follow-Up and Monitoring. Non-Medical Case Management is an ongoing process. Follow-up and monitoring ensures that:

- The resources provided are sufficient to meet the client's needs
- The client is working toward their care plan objectives
- New or changing needs are addressed

During monitoring, the Non-Medical Case Manager should follow-up on referrals and linkage and assess whether the client has further needs. Frequency of follow-up is dependent on client needs and may be done in-person, or by phone; however, follow-up should occur at least every six months at the time of re-certification.

Monitoring

Client Contact - Frequency of client contact by non-medical case managers (i.e. at least once every six months) will be monitored through review of services in ARIES.

Lost to Follow-up. The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period. Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities. See the *Client Transfer and Case Closure* section of this document.

Reassessment/Revision of Care Plan

Non-Medical Case Managers should routinely review the successes and challenges clients are having in achieving outcomes as outlined in the care plan, measure progress in meeting goals and objectives, and revise the plan as necessary.

Revision of care plan: Client assessment and revision to the care plan as appropriate must be made at least every six months, or more frequently as client condition changes.

Documentation: Non-Medical Case Managers must routinely document the outcome of reassessments and service activities in the client record, ARIES, client contact form, and

outcome log (if applicable). Any changes to the care plan should be signed and dated by both the Non-Medical Case Manager and the client if paper based.

Feedback: Non-Medical Case Managers must provide constructive feedback to clients when reviewing the care plan and progress made toward goals and objectives. Constructive feedback is based on concrete observations, and is focused on providing information to the client in a non-judgmental way. Feedback should be strengths-based whenever possible.

Monitoring

Reassessment of Care Plan - Documentation of care plan reassessment and revision will be monitored via review of client charts and/or electronic health records during in-person site visits; timing and quality of the reassessment (including the use of constructive feedback) will be monitored via discussion and client chart review during site visits.

Client Transfer and Case Closure

Transfer of Clients: In the event that a client wishes to (or needs to) transition into Non-Medical Case Management services offered by another agency, relevant intake documents should be forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained. Transfer of clients between agencies or case managers is initiated when:

- The client notifies the case manager that they have moved to a different service area,
- The client notifies the case manager of their intent to transfer services,
- The Forced Disenrollment Grievance Procedure has been followed as defined in the Common Standards of Care, or
- The agency no longer receives funding.

Case Closure: Agencies should close a client's file according to the written procedures established by the agency, as well as those outlined in the Common Standards of Care. A client file may be closed under any of the conditions listed in the Common Standards of Care. Additional circumstances for closing a Non-Medical Case Management case include:

- The client no longer demonstrates need for Non-Medical Case Management due to their own ability to effectively advocate for their needs.
    - Agencies must have written Protocol to "graduate" clients out of Non-Medical Case Management including specific criteria for determining that the client is ready to graduate.
- A client is being incarcerated for more than 6 months.

    - If a client's incarceration is for a period of 6 months or less, the Non-Medical Case Manager should coordinate services with correctional medical staff in order to ensure continuity of case management upon release.
- The client is transitioning into Non-Medical Case Management services offered by another agency, as described above.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Oral Health Care

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Oral Health Care" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Oral Health Care, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Oral Health Care includes outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Key Activities

Allowable activities in this service category include:

- Medical history taking
- Comprehensive oral exam
- Development of an individualized treatment plan, including referral to advanced dental care as needed
- Diagnostic dental care
- Preventive dental care
- Therapeutic dental care
- Oral health education
- Coordination of care with primary care provider and other services

Objective

Oral Health Care services are intended to provide necessary diagnostic, preventive, and therapeutic dental care in order to maintain and improve the oral health of persons living with HIV.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and Oral Health Care staff

Requirements

Provider Qualifications

Education / Experience / Supervision

Professional diagnostic and therapeutic services under this service category must be provided by clinicians licensed by the Dental Board of California. Clinicians can include:

- General Dentists
- Endodontists
- Oral and Maxillofacial Surgeons
- Periodontists

Other professional and non-professional staff may provide services appropriate for their level of training/education, under the supervision of a clinician. These may include, but are not limited to:

- Dental Hygienists (RDH)
- Dental Assistants (RDA, RDAEF)
- Dental Students
- Dental Hygiene Students
- Dental Assistant Students

Any non-clinician staff providing services must be (1) supervised by a clinician; (2) hold current licensure as required by the State of California when applicable; (3) provide services appropriate for their level of training/education; and (4) be trained and knowledgeable about HIV as described below.

Monitoring

Education/Experience/Supervision - Compliance with minimum qualifications for all providers offering diagnostic and therapeutic services, as well as the required licensure of other staff (when applicable), will be monitored by reviewing personnel files Availability of clinical supervision for unlicensed providers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Oral Health Care must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care, and prevention.
- Diagnosis and assessment of HIV-related oral health issues
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including access to dental insurance through ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff Requirements - Maintenance of required licensures will be monitored through HCP desk audit of documentation, and/or review of personnel files during site visits. Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Facility

Any agency providing Oral Health Care must be licensed and comply with current federal and state standards for such programs. In cases where the services can be billed to Denti-Cal, the agency must be a Denti-Cal provider certified by the State of California or be able to document efforts under way to obtain such certifications.

Monitoring

Facility - Agency compliance with facility requirements above will be monitored through direct observation and review of facility documentation during site visits.

Service Characteristics

Providers may provide any or all of the Key Activities included in the ***Service Definition*** section of this document, and may be HCP-funded providers or specialists who receive HCP reimbursement for services but are not a provider in a directly-contracted agency.

Initial Oral Health Care Appointments: Initial Oral Health Care appointments should be made as soon as possible to avoid potential drop out. Emergency or urgent appointments should be provided as soon as possible, on the same day if feasible. Initial non-urgent appointments must occur no later than 90 calendar days after the first client referral. Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after request in order to minimize the need for urgent or emergency services. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with patients. Missed appointments and provider attempts at rescheduling must be documented in the file.

Monitoring

Appointment Times - Wait time between referral and initial appointment, as well as urgent/emergent appointments and subsequent non-urgent appointments, will be monitored through chart review. Agencies will be asked to submit to HCP written policies and procedures for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Eligibility Screening and Intake

The Oral Health Care providers must ensure that the client has been deemed eligible for HCP services by the referring agency; HCP directly-contracted providers should verify that intake has been performed at the start of HCP service provision and if not, perform an intake. See the Common Standards of Care for detailed intake requirements. Providers should ensure that any consents and Releases of Information specific to dental care are completed and in the client's file; providers must take the necessary steps to obtain these forms if missing.

Monitoring

Eligibility Screening and Intake - All Oral Health Care clients served using HCP funding must be registered in ARIES; eligibility screening will be monitored via chart review during site visits. Evidence of all required consent forms and release of information – as well as attempts to obtain them if applicable - will be monitored through review of client chart(s) during site visits.

Initial Assessment

At the start of Oral Health Care Services, a baseline dental evaluation must be conducted. This evaluation should include, at a minimum:

- **Medical history.** The provider shall perform a complete medical history for every new patient. This should include:

    - Client's chief complaint
    - HIV medical care provider
    - Current medication regimen(s) and adherence, including HIV medications
    - Alcohol, drug, and tobacco use
    - Allergies
    - Usual oral hygiene
    - Date of last dental examination, and name of last dentist if known
- **Oral examination.** Each patient should be given a comprehensive oral examination and assessment. This examination should include:
    - Documentation of the client's presenting complaint
    - Medical and dental history
    - Caries (cavities) charting
    - X-rays: Full mouth radiographs or panoramic and bitewing x-rays
    - Complete oral hygiene and periodontal exam
    - Comprehensive head and neck exam
    - Complete intra-oral exam, including evaluation for HIV-associated lesions or STIs
    - Soft tissue exam for cancer screening
    - Pain assessment
    - Risk factors
- **Education:** Clients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency. See the *Preventative Care and Maintenance* section of this document for more details.

Referral / Linkage: Clients requiring specialized care should be referred for and linked to such care via the client's case manager and/or HCP care team, with documentation of that referral in the client file and available upon request.

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the client chart.

Monitoring

Initial Assessment - Performance of a timely initial assessment, including evidence of a medical history, oral examination, and education as specified above, as well as provision and documentation of applicable referrals/linkages, will be monitored via site visit chart review.

Treatment Plan

Oral Health Care providers should create an individualized dental treatment plan for each patient. The plan should:

- Identify and prioritize the patient's dental care needs
- Incorporate client input
- Describe the proposed interventions and treatment schedule
- Include any referrals and linkages to specialty care or other needed services
- Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed.

Monitoring

Treatment Plan - Development and revision of individualized treatment plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits. Care plans may be uploaded to ARIES; however, this is not required. Documentation of care plan development per ARIES will be reconciled with the existence of care plans in patient charts during site visits, as applicable.

Preventative Care and Maintenance

Oral Health Care providers should emphasize prevention, early detection of oral disease, and preventive oral health practices. Education shall include:

- Instruction on oral hygiene, including proper brushing, flossing, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- The effect of nutrition on oral health.

NOTE: Toothbrushes, toothpaste, dental floss, and mouth rinses may be purchased under the Food Bank/Home-Delivered Meals service category.

In addition, clients should be scheduled for routine dental health maintenance visits, as follows:

- Routine examinations and prophylaxis twice a year
- Comprehensive cleaning at least once a year
- Other procedures, such as root planing/scaling as needed

Fiscal Management

HCP will pay for Oral Health Care services for clients not eligible for Denti-Cal or where there are no Denti-Cal providers within 30 minutes or 15 miles of a client's residence or workplace. Providers must show adequate documentation of the time/distance exception. In these situations, HCP will pay no more than 110% over the defined Denti-Cal Current Dental Terminology (CDT) code rate when using a provider who does not take Denti-Cal. HCP funds cannot be used to supplement Denti-Cal.

Monitoring

Fiscal Management - In cases where clients are eligible for Denti-Cal but no Denti-Cal providers are available (i.e. the "time/distance exception" referenced above), providers must submit documentation to HCP that clearly demonstrates the absence of providers in this time/distance range per a recent review of Denti-Cal providers listed on the DHCS website.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Other Professional Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Other Professional Services" service category of the California HIV Care Program (HCP). It incorporates both former service categories "Legal Services" and "Permanency Planning" as defined by and funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Other Professional Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI), as well as legal assistance in obtaining health insurance coverage and challenging unlawful termination or denial of health insurance benefits
    - Eviction prevention, tenant/landlord disputes, or other housing concerns resulting from HIV discrimination or other issues arising from HIV disease
    - Assisting transgender clients with name changes, documentation, health insurance discrimination, and other related issues in order to facilitate HIV-related care
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under HCP
    - Client representation in HIV-related conservatorship cases
    - Preparation of:
        - Healthcare power of attorney
        - Advance healthcare directives
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and

care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:

  - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
  - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

Program Guidance

In all cases, the provision of legal services, permanency planning, and income tax preparation services must be related to a client's HIV status.

Unallowable services: Services related to the following legal issues are not allowable:

- Criminal cases where the issue is not related to HIV
- Class action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program
- Civil cases not related to HIV, such as divorces or other disputes

Objective

The objective of Other Professional Services is to provide professional consultation services to persons living with HIV.

Units of Service

A Unit of Service (UOS) is a 15-minute contact for professional services between a client and an attorney, permanency planner, or income tax preparer.

Requirements

Provider Qualifications

Education / Experience / Supervision

Other Professional Services must be provided by professionals licensed and registered for these services in the State of California.

Legal services must be coordinated, supervised, and provided by an attorney licensed by the state of California and members in good standing with the State Bar of California. Other professional and non-professional staff may provide legal services appropriate for their level of training/education under the supervision of a staff attorney. These may include, but are not limited to:

- Licensed volunteer attorneys
- Law school graduates

- Law students
- Other legal professionals

Staff will provide all services in accordance with the current American Bar Association's Model Rules for Professional Conduct (http://www.abanet.org/cpr/mrpc/mrpc_home.html) and the State Bar of California's Rules of Professional Conduct (http://rules.calbar.ca.gov/Rules/RulesofProfessionalConduct.aspx).

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Provider qualifications – Proof of compliance with minimum qualifications for all providers offering Other Professional Services must be kept in personnel files, with hire date for review during site visits.

Supervision – Routine provision of individual supervision will be monitored via discussion during site visits.

Service Characteristics

Other Professional Services must include at least one of the activities included in the ***Service Definition*** section of this document. Other key characteristics include:

Eligibility Screening: If the Other Professional Services provider is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Orientation

Each new client enrolled in Other Professional Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Provision of Services

To the extent legally possible and in a manner consistent with the provider's professional code of ethics, providers will provide advice, representation, and advocacy necessary to accomplish the client's goals. Note that while providers advise clients, they do not make decisions on behalf of clients. They must also:

- Inform the client of their responsibility to keep the staff informed of any changes relevant to their case
- Represent, advocate, and negotiate on the client's behalf
- Document all contacts made on the client's behalf
- Copy and keep in the client's file any written communication sent on the client's behalf

- Securely store all client records

Documentation: A case file should be maintained for each client. All client contacts, services, and referrals made must be recorded in the client file, privileged information should be kept in a separate file. Additional information recorded in the client file must include:

- Verification of client eligibility;
- A description of how the legal services are necessitated by the HIV status of the client;
- Types of services provided; and
- Hours spent in provision of such services.

Monitoring

Documentation – Presence of a written case file outlining each client's needs and documentation of services provided, will be monitored via site visit file review.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Outpatient/Ambulatory Health Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Outpatient/Ambulatory Health Services" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Outpatient/Ambulatory Health Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, (2) Requirements, and (3) Tools and Resources.

Service Definition

HRSA Definition

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency department or urgent care services are not considered outpatient settings.

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category, whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

Key Activities

Allowable activities in this service category include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues

- Referral to and provision of specialty care related to HIV diagnosis
- Continuing care and management of chronic conditions

Objective

Outpatient/Ambulatory Health Services are intended to provide primary medical care for the treatment of HIV infection consistent with the most recent U.S. Public Health Service (PHS) guidelines, also known as Health and Human Services (HHS) guidelines, including access to antiretroviral and other drug therapies such as prophylaxis and treatment of opportunistic infections.

Units of Service

A Unit of Service (UOS) in this service category includes

1) A 15-minute contact between a client and Outpatient/Ambulatory Care staff
2) Providing a laboratory test
3) Providing a single item of durable medical equipment
4) Providing medication

Requirements

Provider Qualifications

Education / Experience / Supervision

Professional diagnostic and therapeutic services under this service category must be provided by one of the following clinicians licensed by the State of California and operating within the scope of their license:

- Physicians (MD/DO)
- Physician's Assistant (PA)
- Nurse Practitioner (NP)

Other professional and non-professional staff may provide services appropriate for their level of training, education, and licensure as part of a care team in coordination with or under the supervision of a clinician in a manner consistent with State of California requirements for licensure or certification. These staff may include, but are not limited to:

- Nurses (RN, LVN/LPN)
- Medical assistants (MA)
- Pharmacists
- Pharmacy assistants

Any non-clinician staff providing services must be (1) supervised by a clinician; (2) hold current licensure as required by the State of California when applicable; (3) provide services appropriate for their level of training/education; and (4) be trained and knowledgeable about HIV as described below.

Monitoring

Provider Qualifications - Compliance with minimum qualifications for all providers offering diagnostic and therapeutic services, as well as the required licensure of clinical and non-clinical staff (when applicable), will be monitored during site visits. Availability of clinician supervision for unlicensed providers will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All staff providing Outpatient/Ambulatory Health Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention
- HIV counseling and testing
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Facility

Any agency providing Outpatient/Ambulatory Health Services must be licensed and Medi-Cal certified by the State of California, and must comply with current federal and state standards for such programs.

Monitoring

Facility - Agency compliance with facility requirements above will be monitored through review of facility documentation during in-person site visits.

Service Characteristics

Outpatient/Ambulatory Health Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. Providers may provide any or all of the Key Activities included in the *Service Definition* section of this document.

Eligibility Screening: If the Outpatient/Ambulatory Care provider is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Monitoring

Eligibility - All Outpatient/Ambulatory Care clients served using HCP funding must be registered in ARIES; eligibility screening will be monitored via chart review during site visits.

Initial Outpatient/Ambulatory Care Appointments: Initial Outpatient/Ambulatory Health Services appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days after the first client request or referral from another provider, but should be scheduled sooner whenever possible. In order to facilitate rapid initiation of antiretroviral therapy, persons newly diagnosed with HIV should have their first appointment occur within 24 hours of diagnosis.

Non-urgent appointments and appointments for existing patients must be scheduled as soon as feasible, but no more than 60 days after client request in order to minimize the need for urgent or emergency services, or the interruption of services. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented in the file.

Monitoring

Appointments - Timeframe for intake appointments for new clients will be monitored through chart review. Agencies will be asked to submit to HCP policies for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Intake

The Outpatient/Ambulatory Health Services provider must ensure that the client intake has been performed at the start of HCP service provision and it not, perform an intake. See the *Common Standards of Care* for detailed intake requirements. Providers should ensure that any consents and Releases of Information specific to health care are completed and in the client's file. If these documents are missing, providers must take steps to obtain them.

Orientation

Each new client receiving Outpatient/Ambulatory Health Services must receive an orientation to available services at the facility; document this orientation in the client file.

Initial Assessment

- **Medical evaluation:** At the start of Outpatient/Ambulatory Health Services, a baseline medical evaluation must be conducted. This evaluation should be performed in accordance with HHS guidelines, HIV primary care guidelines and CDPH STD guidelines.
- **HIV education:** Patients should always be provided with information regarding the results of diagnostic tests, prognosis, risks and benefits of treatment, instructions on treatment management and follow up, and treatment adherence. In addition, they should be given HIV risk reduction and prevention education.
- **Partner Services:** Per HCP Management Memo 15-06, HCP providers funded for Outpatient/Ambulatory Care Services must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Referral / Linkage: Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.

Documentation: All patient contacts, findings, procedures, diagnoses, education and other information pertinent to patient care must be recorded in the patient chart.

Monitoring

Documentation - Performance of a timely initial assessment, along with complete documentation of assessment findings, existence of a comprehensive laboratory/diagnostic evaluation, and provision of applicable referrals/linkages, will be monitored via site visit chart review.

Treatment Plan

Outpatient/Ambulatory Care Service providers should create an individualized treatment plan for each patient that identifies and prioritizes the patient's medical care needs and incorporates client input. All treatment plans must be signed and dated by a provider, and should follow national guidelines as outlines in the HHS guidelines and HIV primary care guidelines including review and reassessment of the plan at each care appointment.

Tools and Resources

Clinical Guidelines for ARVs, laboratory testing, and other services within the Outpatient/Ambulatory Care Services category are available at:

https://aidsinfo.nih.gov/guidelines

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Outreach Services

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TABLE OF CONTENTS

Introduction

This document describes the "Outreach Services" service category of HCP, funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP. This document highlights each of the requirements and standards that apply to Outreach Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Outreach Services include the provision of the following three activities:

- Identification of people who did not previously know they were living with HIV, and linkage into medical care
- Provision of additional information and education on health care coverage options
- Reengagement of people who already know they are living with HIV into medical care

Program Guidance

Outreach programs must be:

- Conducted at times and in places where identified priority populations are likely to be present. Priority populations should be identified by using surveillance and continuum of care data.
- Planned and delivered in coordination with other local and state HIV prevention outreach and care programs in order to avoid duplication of effort

Monitoring

Priority Populations - Focusing on priority populations for outreach and scheduling of outreach to occur where/when people at high risk for HIV are present will be monitored during site visits through discussion and review of data used to guide outreach.

Unallowable Activities

Outreach Services **may not:**

- Be used to pay for HIV counseling or testing
- Be used for outreach activities that exclusively promote HIV prevention education
- Be used for broad outreach activities, such as providing leaflets at a subway stop or posters at bus shelters
- Supplant funding for outreach activities funded by the Centers for Disease Control and Prevention or other federal, state, or local sources

Monitoring

Allowable Activities - Use of HCP funds for Outreach Services that include only allowable activities (notably excluding HIV counseling and testing) will be monitored through submission of budgets, as well as site visits. Coordination of services with local outreach/prevention programs will be monitored via desk audit of program budget forms.

Objective

Outreach Services are intended to identify people who are unaware of their HIV-positive status or those who know their status but have fallen out of care so that they may become aware of and be enrolled in care and treatment services.

Requirements

Provider Qualifications

Education/Experience/Supervision

There are no minimum educational standards. All Outreach Services staff must be trained and knowledgeable about HIV and familiar with available HIV resources in the area. They should have good communication skills and ideally be culturally and linguistically competent and able to meet the needs of the community served.

Regardless of education/training, staff should be aware of the demographics in the service area, and trained and experienced in the following:

- Outreach
- HIV transmission and prevention
- Local HIV service delivery system, especially primary medical care and case management services
- Motivational interviewing

Staff Orientation and Training

Initial: All staff providing Outreach Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including HOPWA and ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Service Characteristics

Outreach Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. Outreach Services providers must provide the three key activities included in the ***Service Definition*** section of this document.

Service Coordination: Services must be planned and delivered in coordination with local HIV prevention programs to avoid duplication of effort. The services paid for by HCP under this standard cannot take the place of HIV prevention services offered by other programs.

Priority Populations: Services must be focused to populations and communities known to be at disproportionate risk of HIV infection. Broad-scope awareness activities for the general public, such as transit ads, are NOT considered focused services.

Key Locations: Services should be conducted at times and places where there is a high probability that people living with HIV will be reached. Examples of this include offering services at specific establishments frequented by people likely to have participated in high-risk behavior and offering services at times outside of normal business hours.

HIV education: Clients should always be provided with HIV risk reduction and prevention education, information about partner services, and referrals to the HIV service delivery system including clear information on how to access those services.

Monitoring

HIV Education - The provision of HIV risk reduction and prevention education counseling, education about the HIV service delivery system and information about how to access services, and general health improvement counseling will be monitored through submission to HCP of educational materials used during Outreach Services and discussion during site visits.

Referral / Linkage: Clients should be referred for testing as appropriate; those testing positive for HIV should be referred and linked to HIV medical care, case management, benefits counseling, and other services necessary to maintain or improve health outcomes as appropriate, using a warm hand off where possible. Documentation of that referral must be in the client file and available upon request.

Monitoring

Referral / Linkage - Provision and documentation of referrals for clients to HIV testing as appropriate, and linkage for clients living with HIV to medical care and case management, will be monitored through discussion during site visits.

Partner Services: Per HCP Management Memo 15-06, HCP providers funded for Outreach Services must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Monitoring

Partner Services - Existence of a protocol and process for Partner Services counseling and referral will be monitored by submission of written policies and procedures documentation to HCP. Implementation of the protocol (i.e. that clients are actually offered Partner Services information and referrals) will be monitored through observation and chart review during site visits.

Quantifiable: Providers should obtain client information and keep a record of each contact, including information/education provided and any referrals or linkages.

Monitoring

Documentation - Documentation of client contacts and overall program results will be monitored in ARIES Outreach Services Module or ARIES.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Psychosocial Support Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Psychosocial Support Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Psychosocial Support Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns.

Program Guidance

HCP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds under this service category may not be used to pay for: nutritional supplements (See Food Bank/Home Delivered Meals service category), social/recreational activities, or gym memberships.

Funds under this service category may not be used to pay for services provided by a licensed mental health provider (see Mental Health Services service category.)

Key Activities

Key activities of Psychosocial Support Services may include:

- HIV support groups
- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services for services provided by Registered Dietitians)
- Child abuse and neglect counseling
- Pastoral care/counseling services
- Bereavement counseling

Psychosocial Support Services can be provided in individual and/or group settings.

Objective

The objective of Psychosocial Support Services is to increase client self-efficacy and create a broad-based support system that makes resources available as needed.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a counselor or other provider of allowed Psychosocial Support Services. When clients attend group-related services, sign-in sheets should be maintained and UOS should be allotted for each client (e.g., if five clients attend a one-hour support group, the service should be recorded for each client as four units at 15 minutes apiece; See ARIES Policy Notice E4).

Requirements

Provider Qualifications

Education / Experience / Supervision

Psychosocial Support Services practitioners are not required to be licensed or registered in the State of California. Providers should be trained and knowledgeable in HIV-related issues. Individual supervision and guidance must be available to all staff as needed.

Exception: Pastoral care/counseling services must be provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, or as a component of services provided by a licensed provider, such as a home care or hospice provider).

Monitoring

Supervision - Availability of individual supervision will be monitored via discussion during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Psychosocial Support Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Service Characteristics

Psychosocial Support Services must be offered in a way that addresses barriers to accessing health care and uses resources to support positive health outcomes for clients. When relevant, these services should be coordinated with a client's overarching Care Plan. All Psychosocial Support Services must include at least one of the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Eligibility Screening: If the Psychosocial Support Services provider is the client's first contact with HCP, the client must be screened for eligibility as described in the Common Standards of Care.

Initial Psychosocial Support Services Appointments: Initial Psychosocial Support Services appointments should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 30 calendar days of first client referral, but should be scheduled sooner whenever possible. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Monitoring

Appointment scheduling and follow-up – In advance of site visits, agencies will be asked to submit to HCP written policies for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Orientation

Each new client enrolled in Psychosocial Support Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Treatment Provision

Requirements: Treatment plans are recommended for high-acuity clients, although they are not generally required for this service category. Psychosocial Support Services providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Reviews and incorporates the existing Care Plan, if any

- Identifies the client's needs, personal support systems, and services they are currently receiving
- Includes individual and/or group counseling sessions
- Provides education and information that will enhance the client's well-being, including health education, risk reduction, drug/medication use, and nutritional information
- Provides allowable, needed services to family members and significant others with the goal of developing and strengthening the client's support system
- Coordinates with the client's existing providers, such as mental health and substance use case managers
- Coordinates and makes referrals to outside providers as needed
- Is signed and dated by the provider unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the ARIES record)

Documentation: Psychosocial Support Services should be provided in a way that is consistent with the individual service plan. All services provided should be documented in the client's chart.

Monitoring

Service plans – Presence of a written individual service plan for high-acuity clients outlining each client's needs and progress will be monitored via site visit chart review, including documentation of services provided.

Pastoral care/counseling (if provided) – Documentation that the pastoral care/counseling program is provided by an institutional pastoral care program and that the program is available to all HCP-eligible clients without regard to religious affiliation will be monitored will be monitored via site visit discussion.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Referral for Health Care and Support Services

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Referral for Health Care and Support Services" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

This document highlights the requirements and standards that apply to Referral for Health Care and Support Services, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Referral for Health Care and Support Services directs a client to needed core medical or support services in-person or through telephone, written, or other type of communication. These services are provided outside of an Outpatient/Ambulatory Health Services, Medical Case Management, or Non-Medical Case Management visit. Services funded through this category are intended for low-acuity clients with sporadic service needs only. Those with ongoing need for referrals and support should be linked to non-medical care management.

This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medi-Cal, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance marketplace plans).

Program Guidance

Referrals for health care and support services provided by outpatient/ambulatory health care providers should be reported under Outpatient/Ambulatory Health Services.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Key Activities

Key activities of Referral for Health Care and Support Services include:

- Screening for client's overall service needs;
- Referrals to assist clients in obtaining access to public and private programs, such as:

    - Benefits and Entitlements counseling and referral
        - Medi-Cal
        - Medicare Part D
        - California State Pharmacy Assistance Program (Cal Rx)
        - Health insurance marketplace plans (Covered California)
        - AIDS Drug Assistance Program (ADAP)
    - Other state or local health care supportive services related to:
        - housing (including the Housing Choice Voucher Program)
        - legal
        - medical care
        - mental health services
        - oral health care
        - substance use disorder
        - food assistance programs
        - support groups
- Follow-up to assess client's access to referred services and progress in addressing needs.

Objective

Referral for Health Care and Support Services is designed to link persons living with HIV to needed medical or support services.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a referral provider, whether by phone or face-to-face.

Requirements

Provider Qualifications

Education / Experience / Supervision

There are no specific education or licensing requirements. Services may be provided informally by community health workers or support staff, or as part of an outreach program. However, services must be provided by persons who possess a comprehensive knowledge of:

- Services and benefits available in the local area
- HIV and related issues

Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training

Initial: All HCP-funded staff providing Referral for Health Care and Support Services must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care, including ADAP

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes.

Service Characteristics

Referral for Health Care and Support Services must be offered in a way that addresses barriers to accessing needed care and services and uses resources to support positive health outcomes for clients. All Referral for Health Care and Support Services must include the Key Activities included in the Service Definition section of this document. Other best practices include the use of reminder systems and flexible policies regarding missed appointments when possible.

Screening and Referrals: Initial Referral for Health Care and Support Services appointments should be made as soon as possible to avoid potential drop out; services may be included as part of an outreach program. Initial contact (e.g., intake to HCP services if needed, screening for service needs, and referral using a warm handoff if possible) must occur no more than 10 business days after first client contact and must address immediate needs. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Monitoring

Appointment scheduling and follow-up – In advance of site visits, agencies will be asked to submit to HCP written policies for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Orientation

Each new client enrolled in Referral for Health Care and Support Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Screening for Service Needs

In addition to making a referral as requested by the client, providers in this service category must work with the client to screen for other service needs. Referrals should be made to all appropriate services within 30 days of initial orientation to this service category. Referrals should be provided via warm handoff when possible.

Documentation: For all client contacts, documentation of referrals, benefits counseling, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, provision of applicable referrals/linkages, and follow-up will be monitored via site visit chart review.

Providing Referrals

Providers should assist clients in accessing all services needed, including:

Benefits and Entitlements Counseling: Clients should be provided with benefits and entitlements counseling. Counseling and referral should include all appropriate federal, state (including ADAP), local, or manufacturer's assistance programs.

Supportive Services: Clients should also be referred to case management, medical, and non-medical supportive services, as appropriate.

Follow-up: Staff must follow-up with the client to assess the client's progress in addressing their needs. Follow-up appointments should include referrals to any additional services needed as determined during the session.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Substance Abuse Outpatient Care

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Substance Abuse Outpatient Care" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

NOTE: *For clarity and consistency, the service category referenced throughout this document is Substance Abuse Outpatient Care, per PCN #16-02. However, in all other cases, HCP utilizes 2016 White House Office on National Drug Control Policy (ONDCP) language, including "substance use disorder" instead of "substance abuse."*

This document highlights the requirements and standards that apply to Substance Abuse Outpatient Care, and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

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

Key Activities

Key activities of Substance Abuse Outpatient Care include:

- Initial assessment of the client's service needs;
- Recovery readiness determination and relapse prevention strategies;

- Harm reduction including syringe access;
- Development of a comprehensive, individualized treatment plan including client-driven goals and milestones;
- Treatment provision, such as:
    - Behavioral health counseling in individual, family, and/or group settings
    - Crisis intervention
    - Medication-assisted therapy, including the use of disulfiram, acamprosate, naltrexone, methadone, buprenorphine, and others
    - Relapse prevention
- Referral/coordination/linkages with other providers to ensure integration of services and better client care;
- Re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary;
- Development of follow-up plans;

Acupuncture therapy may be allowable under this service category only when it is included in an individualized treatment plan as part of a substance use disorder treatment program funded under the RWHAP.

Syringe access services are allowable for HCP clients to the extent that they comport with current appropriations law and applicable US Health and Human Services guidance, including HRSA/ HAB-specific guidance. Syringes may not be purchased using Ryan White funds. Jurisdictions wishing to use RWHAP funds for syringe access services should consult with HCP.

Objective

Substance Abuse Outpatient Care is designed to assist clients in reducing and/or eliminating use of alcohol, legal, and/or illegal drugs through harm reduction strategies.

Limitations

Only non-residential services may be provided under this service category. Residential substance use disorder services must be provided under the Substance Abuse Treatment (residential) category.

Units of Service

A Unit of Service (UOS) is a 15-minute contact between a client and a substance use disorder treatment provider, other counselor, or acupuncturist.

Requirements

Provider Qualifications

Education / Experience / Supervision

Professional diagnostic, therapeutic, and other treatment services under this service category must be provided by practitioners holding appropriate and valid California licensure or certification, including:

- Physicians (including Psychiatrists)
- Psychologists
- Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)
- California Alcohol and Drug Abuse Counselors (CADAC)
- Acupuncturists

Monitoring

Provider qualifications – Proof of compliance with minimum qualifications for all providers offering diagnostic and therapeutic services must be kept in personnel files, with hire date for review during site visits.

Other professional and non-professional ("waivered") staff may provide services appropriate for their level of training/education as part of a care team under the supervision of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Non-professional staff include but are not limited to:

- Peer Navigators
- Community Health Workers
- Trainees

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Supervision and guidance by a clinician – Availability of supervision and guidance by a clinician for unlicensed providers will be monitored via discussion during site visits. Assurance that all services provided are commensurate with the training and education of providers will be verified through in-person chart review during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Substance Abuse Outpatient Care must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Trauma and stigma for people living with HIV, and the effect of trauma and stigma on care/relapse
- Harm reduction principles and strategies
- Overdose education and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

Monitoring

Staff training – Knowledge and training related to HIV care and substance use for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Service Characteristics

Substance Abuse Outpatient Care must be offered in a way that addresses barriers to accessing substance use disorder treatment and uses resources to support positive health outcomes for clients. All Substance Abuse Outpatient Care must include the Key Activities included in the *Service Definition* section of this document. Providers

While not specifically required, other best practices recommended for this service include:

- Provision of low-threshold services; agency guidelines should avoid abstinence requirements tied to service provision
- Use of peer-based support strategies

- Use of a trauma-informed approach
- Use of reminder systems and flexible policies regarding missed appointments

Initial Appointments: Initial Substance Abuse Outpatient Care appointments should be made as soon as possible to avoid potential drop out. Initial in-person contact (e.g., intake, initial screening, and scheduling of a full assessment) must occur no more than five business days after first client referral and must address immediate needs. Full assessments may occur later but no more than 30 calendar days after the initial in-person contact. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Monitoring

Appointment scheduling and follow-up – In advance of site visits, agencies will be asked to submit to HCP written policies for client follow-up after missed appointments; documentation of rescheduling attempts will be monitored via chart review during site visits.

Orientation

Each new client enrolled in Substance Abuse Outpatient Care must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment

The substance use disorder provider must conduct a comprehensive face-to-face needs assessment within 35 days of referral. The needs assessment will describe the client's current status and inform the treatment plan. This substance use needs assessment should include:

- Substance use history
- Current medications and side effects
- A detailed statement of the client's current presenting problem
- Mental status exam (MSE)
- Concurrent diagnoses, including physical and mental health diagnoses

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, and provision of applicable referrals/linkages, will be monitored via site visit chart review. Primary care provider referral for acupuncture services will be monitored via site visit chart review.

Treatment Plan

Frequency: An individualized treatment plan must be developed within 30 calendar days of the client's initial assessment and re-evaluated at least every six months thereafter, with adaptations as needed.

Requirements: Substance use disorder providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Identifies and prioritizes the client's mental health care needs, including those not directly related to substance use
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment
- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and substance use disorder team
- Identifies interventions, modalities, and resources to attain the goals and objectives, including referral and linkage to other relevant providers (e.g., mental health providers, physicians, housing specialists)
- Details frequency and expected duration of services
- Is signed and dated by the provider unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the ARIES record)

Treatment Provision

Services should be provided utilizing methodologies appropriate for the client's needs, following evidence-based recommendations for substance use disorder treatment for people living with HIV. These may include any combination of:

Group and individual therapy/counseling: Outpatient substance use disorder counseling may be done in groups, individually, or a combination of the two.

Harm Reduction Model: Services should utilize harm reduction principles and should be offered for all substances as appropriate. Programs may include syringe access services, but services funded through HCP can only be provided to HCP clients and cannot include purchase of syringes.

Recovery readiness: Services should include an evaluation of the client's readiness to abstain from substance use for the foreseeable future.

Medication-assisted treatment: Licensed narcotic treatment programs may combine pharmacotherapy such as methadone, buprenorphine, and naloxone with counseling and behavioral therapy. Medications must be prescribed by a licensed and appropriately certified/registered medical provider (with buprenorphine certification, if applicable). *Note: buprenorphine services may also be provided under the Outpatient/Ambulatory Health Services category if preferred.*

Relapse prevention: Services should provide education and counseling to help prevent relapse. These may include recovery planning and self-help groups as well as coping strategies for common relapse triggers.

Acupuncture: While acupuncture may not be utilized as the dominant treatment modality, it is an acceptable adjunct therapy when provided per a written referral from the client's primary care provider. Referrals and services must be documented in the treatment plan.

Referral / linkage: Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH (CDPH) OFFICE OF AIDS (OA)
HIV CARE PROGRAM (HCP) STANDARDS OF CARE

Substance Abuse Services (residential)

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

Table of Contents

Introduction

This document describes the "Substance Abuse Services (residential)" service category of the California HIV Care Program (HCP), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. It serves as a supplement to the Common Standards of Care document also released by HCP.

NOTE: *For clarity and consistency, the service category referenced throughout this document is "Substance Abuse Services (residential)", per PCN #16-02. However, in all other cases, HCP utilizes 2016 White House Office on National Drug Control Policy (ONDCP) language, including "substance use disorder" instead of "substance abuse".*

This document highlights the requirements and standards that apply to Substance Abuse Services (residential), and must be followed by any provider receiving HCP (Ryan White Part B) funding for this service category.

How This Document is Organized

Within this document, the Standards of Care are described in terms of (1) Service Definition, and (2) Requirements.

Service Definition

HRSA Definition

Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis and treatment of substance use disorder. Services include:

- Screening
- Assessment
- Diagnosis and/or treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Medication-assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention
    - Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance

Substance Abuse Services (residential) are permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under HCP.

Acupuncture therapy may be allowable under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under HCP.

HCP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license.

Key Activities

Key activities of Substance Abuse Services (residential) include:

- Short-term room and board to support treatment of substance use disorder;
- Initial assessment of the client's service needs;
- Pretreatment/recovery readiness programs and relapse prevention strategies;
- Harm reduction, including syringe access;
- Development of an individualized treatment plan with client-driven goals and milestones;
- Treatment provision, including:
    - Behavioral health counseling in individual, family, and/or group settings
    - Crisis intervention
    - Medication-assisted therapy, including the use of disulfiram, acamprosate, naltrexone, methadone, buprenorphine, and others
    - Relapse prevention
    - Acupuncture, as part of a documented plan and with referral from primary care provider
- Referrals to detoxification services;
- Coordination/linkages with other providers to ensure integration of services and better client care;
- Re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary; and
- Development of follow-up and discharge plans.

Objective

Substance Abuse Services (residential) is designed to assist clients in reducing and/or eliminating use of alcohol, legal, and/or illegal drugs through harm reduction strategies in order to improve the overall health and social wellness of HIV-positive adults.

Limitations

Only residential services may be provided under this category. Non-residential substance use disorder services must be provided under Substance Abuse Outpatient Care.

Units of Service

A Unit of Service (UOS) is a single 24-hour day of residential substance use treatment and/or detoxification, or a 15-minute partner notification contact.

Requirements

Provider Qualifications

Education / Experience / Supervision

Professional diagnostic, therapeutic, and other treatment services under this service category must be provided by practitioners holding appropriate and valid California licensure or certification, including:

- Physicians (including Psychiatrists)
- Psychologists
- Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)
- California Alcohol and Drug Abuse Counselors (CADAC)
- Acupuncturists

At least 30% of program staff providing counseling services in a substance use treatment program must be licensed or certified pursuant to the requirements of California Code of Regulations, Title 9, Division 4, Chapter 8.

Monitoring

Provider qualifications – Proof of compliance with minimum qualifications for all providers offering diagnostic and therapeutic services must be kept in personnel files, with hire date for review during site visits.

Other professional and non-professional ("waivered") staff may provide services appropriate for their level of training/education, as part of a care team under the supervision of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Non-professional staff include but are not limited to:

- Peer Navigators
- Community Health Workers
- Trainees

Individual supervision and guidance must be routinely provided to all staff.

Monitoring

Supervision and guidance by a clinician – Availability of supervision and guidance by a clinician for unlicensed providers will be monitored via discussion during site visits. Assurance that all services provided are commensurate with the training and education of providers will be verified through in-person chart review during site visits.

Staff Orientation and Training

Initial: All HCP-funded staff providing Substance Abuse Services (residential) must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Trauma and stigma for people living with HIV, and the effect of trauma and stigma on care/relapse
- Harm reduction principles and strategies
- Overdose education and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP

Ongoing: Staff must also receive ongoing annual training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

Monitoring

Staff training – Knowledge and training related to HIV care for all staff will be verified through personnel file documentation of hire date, all trainings provided, and dates of trainings; these records must be available for review during site visits or upon request.

Facility

Any agency providing medication-assisted treatment for substance use disorder must be accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). If the facility primarily provides inpatient medical or psychiatric care, the component providing the residential substance use treatment must be separately licensed for that purpose.

Service Characteristics

Substance Abuse Services (residential) must be offered in a way that addresses barriers to accessing substance use disorder treatment and uses resources to support positive health outcomes for clients. All Substance Abuse Services (residential) must include the Key Activities included in the ***Service Definition*** section of this document.

While not specifically required, other best practices recommended for this service include:

- Provision of low-threshold services; agency guidelines should avoid abstinence requirements tied to service provision
- Use of peer-based support strategies
- Use of a trauma-informed approach

Orientation

Each new client enrolled in Substance Abuse Services (residential) must receive an orientation to the services on admission; document this orientation in the client file.

Initial Assessment

The substance use disorder provider must conduct a comprehensive initial assessment for services. The needs assessment will describe the client's current status and inform the treatment plan. The substance use needs assessment should include:

- Substance use history
- Current medications and side effects
- A detailed statement of the client's current presenting problem
- Mental status exam (MSE)
- Concurrent diagnoses, including physical and mental health diagnoses

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to client care must be recorded in the client chart.

Monitoring

Assessments – Performance of a timely initial assessment, along with complete documentation of assessment findings, and provision of applicable referrals/linkages, will be monitored via site visit chart review. Primary care provider referral for acupuncture services will be monitored via site visit chart review.

Treatment Plan

Frequency: An individualized treatment plan must be developed upon the client's admission, and re-evaluated at least every 90 days thereafter or more frequently if needed.

Requirements: Substance use disorder providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment
- Identifies and prioritizes the client's mental health care needs, including those not directly related to substance use
- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and substance use disorder team
- Include a plan for adherence to the HIV medical plan
- Details expected duration of services
- Ensures coordination of care, through collaboration with the client's service providers (medical provider, case manager, mental health specialist, etc.)
- Is signed and dated by the provider, unless documented via the Care Plan in ARIES (in which case the responsible staff person should be indicated in the record)

Discharge: The treatment plan must detail the terms of discharge, including the conditions that must be met for discharge to occur, and ways in which care will be coordinated with the client's outpatient case manager or other supportive person, to help prevent relapse.

Treatment Provision

Services should be provided utilizing methodologies appropriate for the client's needs, following evidence-based recommendations for substance use disorder treatment for people living with HIV. These may include any combination of:

Group and individual therapy/counseling: Substance use disorder counseling may be done in groups, individually, or a combination of the two.

Harm Reduction Model: Services should utilize harm reduction principles and should be offered for all substances as appropriate. Programs may include syringe access services, but cannot include purchase of syringes.

Recovery readiness: Services should include an evaluation of the client's readiness to abstain from substance use for the foreseeable future.

Medication-assisted treatment: Licensed narcotic treatment programs may combine pharmacotherapy such as methadone, buprenorphine, and naloxone with counseling and behavioral therapy. Medications must be prescribed by a licensed and appropriately certified/registered medical provider. *Note: buprenorphine services may also be provided under the Outpatient/Ambulatory Health Services category if preferred.*

Relapse prevention: Services should provide education and counseling to help prevent relapse. These may include recovery planning and self-help groups as well as coping strategies for common relapse triggers.

Acupuncture: While acupuncture may not be utilized as the dominant treatment modality, it is an acceptable adjunct therapy when provided per a written referral from the client's primary care provider. Referrals and services must be documented in the treatment plan.

Referral / linkage: Clients requiring specialized care should be referred for and linked to such care utilizing a warm hand off when possible, with documentation of that referral in the client file and available upon request.

Exhibit D.1

Subrecipient Name:	County of Monterey Health Department	Program Contact Name:	Brandon Gates
Agency Address:	1270 Naitvidad Rd., Salinas, CA 93906	Email Address:	Gatesb@co.monterey.ca.us
Grant Number:		Phone Number:	831-755-4698
DUNS:		Fiscal Contact Name:	
Tax ID Number:		Email Address:	
CDFA:	93.917	Phone Number:	

Initial Budget Five Line Item Budget	
Personnel	$0
Operating Expenses	$0
Capital Expenditures	$0
Other Cost	$27,000
Indirect Cost	$0
Total	$27,000

Total Admin	$0
Admin Check	Within Cap Limit

Initial Budget Subcontractor(s) Summary	Subcontractor(s) Budget	DUNS Number	Federal tax ID #
Access Support Network (ASN)	$27,000		

Budget Revision #1 Five Line Item Budget	
Personnel	$0
Operating Expenses	$0
Capital Expenditures	$0
Other Cost	$27,000
Indirect Cost	$0
Total	$27,000

Total Admin	$0
Admin Check	Within Cap Limit

Budget Revision #1 Subcontractor(s) Summary	Subcontractor(s) Budget	DUNS Number	Federal tax ID #
Access Support Network (ASN)	$27,000		

Budget Revision #2 Five Line Item Budget	
Personnel	$0
Operating Expenses	$0
Capital Expenditures	$0
Other Cost	$27,000
Indirect Cost	$0
Total	$27,000

Total Admin	$0
Admin Check	Within Cap Limit

Budget Revision #2 Subcontractor(s) Summary	Subcontractor(s) Budget	DUNS Number	Federal tax ID #
Access Support Network (ASN)	$27,000		

Budget Revision #3 Five Line Item Budget	
Personnel	$0
Operating Expenses	$0
Capital Expenditures	$0
Other Cost	$27,000
Indirect Cost	$0
Total	$27,000

Total Admin	$0
Admin Check	Within Cap Limit

Budget Revision #3 Subcontractor(s) Summary	Subcontractor(s) Budget	DUNS Number	Federal tax ID #
Access Support Network (ASN)	$27,000		

Table 1- Core and Supportive Services Personnel Details

Subrecipient Name: County of Monterey Health Department

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00
						$0.00		$0.00

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel
					$0.00		$0.00	$0.00
				0.01	$0.00		$0.00	$0.00
					$0.00		$0.00	
					$0.00		$0.00	
					$0.00		$0.00	
					$0.00		$0.00	
					$0.00		$0.00	
					$0.00		$0.00	
					$0.00		$0.00	$0.00

Table 3- Non-Personnel Details

HCP Service Category	HCP Budget	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
	$0.00			

Table 5- Client Count

HCP Service Category	Estimated Client Count

Table 4- Administrative Budget

Expense Type	HCP Budget	Budget Revision (Yes/No)
Indirect	$0.00	No
Capital		No
Operating		No

Table 6- Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$0.00
Total	$0.00

Initial Personnel Summary

Table 1- Non-Administrative Staff Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subrecipient: County of Monterey Health Department

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No

Table 1- Non-Administrative Staff Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)
Food Bank / Home Delivered Meals	Blanca Barron	Blanca will place Instacart orders for clients to arrange home delivery of meals and household cleaning products.	No
Emergency Financial Assistance	Blanca Barron	Blanca will assist clients needing cell phones in order to maintain contact with case managers and other service providers. Blanca will assist clients and staff needing personal protective equipment to maintain protection from COVID-19	No
Mental Health Services	Blanca Barron	Blanca will assist with making referrals to mental health services for clients, via telehealth services.	No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subcontractor: Access Support Network (ASN)

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)
0	0		No
0	0		No
0	0		No
0	0		No
0	0		No

0	0		No
0	0		No
0	0		No

Initial Non-Personnel Summary

Table 1- Non-Personnel Service Category Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Methodology Description	Budget Revision (Yes/No)
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No

Table 2- Administrative Type

Subrecipient: County of Monterey Health Department

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		No
Capital		No
Operating		No

Table 1- Non-Personnel Service Category Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Methodology Description	Budget Revision (Yes/No)
Emergency Financial Assistance	Purchase of Pre-paid smart phones for clients in order to stay in contact with case managers and support remote services provision. Purchase of technology equipment to provide remote eligibility services to clients. Purchase of PPE for RWHAP service case managers and staff. Purchase of	No
Food Bank / Home Delivered Meals	Purchase of household cleaning supplies, hand sanitizers, masks and other hygiene products for use by clients-- to maintain protection from COVID-19. Purchase of Instacart orders for clients for home delivery of meals and household cleaning products	No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No
0		No

Table 2- Administrative Type

Subcontractor: Access Support Network (ASN)

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		No
Capital		No
Operating		No

Table 1- Core and Supportive Services Personnel Details

Subrecipient Name: County of Monterey Health Department

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
						$0.00		$0.00

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.01	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
					$0.00		$0.00	$0.00

Table 3- Non-Personnel Details

HCP Service Category	HCP Budget	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
	$0.00			

Table 5- Client Count

HCP Service Category	Estimated Client Count
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0

Table 4- Administrative Budget

Expense Type	HCP Budget	Budget Revision (Yes/No)
Indirect	$0.00	
Capital	$0.00	
Operating	$0.00	

Table 6- Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$0.00
Total	$0.00

BR #1 Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Administrative Staff Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subrecipient: County of Monterey Health Department

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 1- Non-Administrative Staff Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
Food Bank / Home Delivered Meals	Blanca Barron			
Emergency Financial Assistance	Blanca Barron			
Mental Health Services	Blanca Barron			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subcontractor: Access Support Network (ASN)

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

BR #1 Non-Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Personnel Service Category Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subrecipient: County of Monterey Health Department

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Table 1- Non-Personnel Service Category Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
Emergency Financial Assistance			
Food Bank / Home Delivered Meals			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subcontractor: Access Support Network (ASN)

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Table 1- Core and Supportive Services Personnel Details

Subrecipient Name: County of Monterey Health Department

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
0	0	0		$0.00	0.00	$0.00	0.00%	$0.00
						$0.00		$0.00

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.01	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
					$0.00		$0.00	$0.00

Table 3- Non-Personnel Details

HCP Service Category	HCP Budget	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
	$0.00			

Table 5- Client Count

HCP Service Category	Estimated Client Count
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0

Table 4- Administrative Budget

Expense Type	HCP Budget	Budget Revision (Yes/No)
Indirect	$0.00	
Capital	$0.00	
Operating	$0.00	

Table 6- Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$0.00
Total	$0.00

BR #2 Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Administrative Staff Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subrecipient: County of Monterey Health Department

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 1- Non-Administrative Staff Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
Food Bank / Home Delivered Meals	Blanca Barron			
Emergency Financial Assistance	Blanca Barron			
Mental Health Services	Blanca Barron			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subcontractor: Access Support Network (ASN)

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

BR #2 Non-Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Personnel Service Category Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subrecipient: County of Monterey Health Department

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Table 1- Non-Personnel Service Category Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
Emergency Financial Assistance			
Food Bank / Home Delivered Meals			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subcontractor: Access Support Network (ASN)

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Table 1- Core and Supportive Services Personnel Details

Subrecipient Name: County of Monterey Health Department

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
0	0	0		$0.00	0.00	$0.00	0.0%	$0.00
						$0.00		$0.00

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.01	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
0	0		$0.00	0.00	$0.00	0.0%	$0.00	$0.00
					$0.00		$0.00	$0.00

Table 3- Non-Personnel Details

HCP Service Category	HCP Budget	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
0	$0.00		0	0
	$0.00			

Table 5- Client Count

HCP Service Category	Estimated Client Count
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0
0	0

Table 4- Administrative Budget

Expense Type	HCP Budget	Budget Revision (Yes/No)
Indirect	$0.00	
Capital	$0.00	
Operating	$0.00	

Table 6- Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$0.00
Total	$0.00

BR #3 Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Administrative Staff Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subrecipient: County of Monterey Health Department

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 1- Non-Administrative Staff Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Staff Name	Staff Duties Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
Food Bank / Home Delivered Meals	Blanca Barron			
Emergency Financial Assistance	Blanca Barron			
Mental Health Services	Blanca Barron			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

Table 2- Administrative Staff Summary *(or travel summary, if applicable)*

Subcontractor: Access Support Network (ASN)

Staff Name	Position Title	Staff Duty Summary	Budget Revision (Yes/No)	New Staff (Yes/No)
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			
0	0			

BR #3 Non-Personnel Summary

Revision Submission Date:

OA Revision Approval Date:

Table 1- Non-Personnel Service Category Summary

Subrecipient: County of Monterey Health Department

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subrecipient: County of Monterey Health Department

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Table 1- Non-Personnel Service Category Summary

Subcontractor: Access Support Network (ASN)

HCP Service Category	Methodology Description	Budget Revision (Yes/No)	New Service (Yes/No)
Emergency Financial Assistance			
Food Bank / Home Delivered Meals			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Table 2- Administrative Type

Subcontractor: Access Support Network (ASN)

Administrative Type	Administrative Expense Description	Budget Revision (Yes/No)
Indirect		
Capital		
Operating		

Initial Budget

Table 1- Core and Supportive Services Personnel Details

Subrecipient Name: County of Monterey Health Department

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel	HCP Total	Budget Revision (Yes/No)	CQM Budget (Yes/No)
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00	$0.00	$0.00		

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel	HCP Total	Budget Revision (Yes/No)	Travel for Conference Only (Yes)
					$0.00		$0.00	$0.00	$0.00	No	No
				0.01	$0.00		$0.00	$0.00	$0.00	No	No
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00	$0.00	$0.00		

Table 3- Non-Personnel Details

HCP Service Category	HCP Budget	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		
	$0.00			

Table 5- Client Count

HCP Service Category	Estimated Client Count

Table 4- Administrative Budget

Expense Type	HCP Budget	Budget Revision (Yes/No)
Indirect	$0.00	No
Capital		No
Operating		No
Total	$0.00	

Table 6- Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$0.00
Total	$0.00

Table 1- Core and Supportive Services Personnel Details

Subcontractor Name: **Access Support Network (ASN)**

HCP Service Category	Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel	HCP Total	Budget Revision (Yes/No)	CQM Budget (Yes/No)
Food Bank / Home Delivered Meals	Blanca Barron	Case Manager/Eligibility Coordinator		$35,360.00	0.12	$4,243.20	18.00%	$763.78		$5,006.98	No	
Emergency Financial Assistance	Blanca Barron	Case Manager/Eligibility Coordinator		$35,360.00	0.07	$2,536.46	18.00%	$456.56		$2,993.02	No	
Mental Health Services	Blanca Barron	Case Manager/Eligibility Coordinator		$35,360.00	0.05	$1,694.91	18.00%	$305.08		$2,000.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$0.00		$0.00		$0.00	No	
						$8,474.58		$1,525.42	$0.00	$10,000.00		

Table 2- Administrative Personnel Details

Staff Name	Position Title	Tentative Start Date (if applicable)	Annual Salary	HCP FTE	HCP Salary	Fringe Percent	Fringe Benefits	Travel	HCP Total	Budget Revision (Yes/No)	Travel for Conference Only (Yes)
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00		$0.00	No	
					$0.00		$0.00	$0.00	$0.00		

Table 3- Non-Personnel Details

HCP Service Category	HCP Amount	Budget Revision (Yes/No)	CQM Budget (Yes/No)	CQM Activity
Emergency Financial Assistance	$10,000.00	No		
Food Bank / Home Delivered Meals	$7,000.00	No		
		No		
		No		
		No		
		No		
		No		
		No		
		No		

Table 5- Client Count

HCP Service Category	Estimated Client Count
Emergency Financial Assistance	100
Food Bank / Home Delivered Meals	50
Mental Health Services	25

		No		
		No		
		No		
		No		
		No		
	$17,000.00			

Table 4- Administrative Budget

Expense Type	Budget Amount	Budget Revision (Yes/No)
Indirect		No
Capital		No
Operating		No
Total	$0.00	

Table 6: Total HCP Budget

Funding Type	Budget Amount
Admin	$0.00
Non-Admin	$27,000.00
Total	$27,000.00