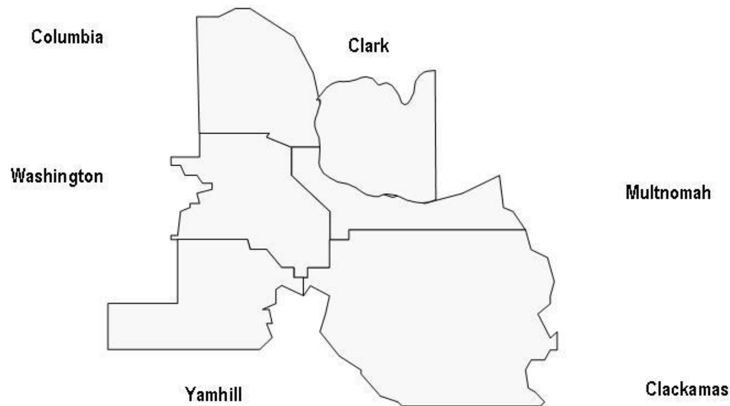
Portland OR TGA
Standards of Care

Including Standard Contract Conditions



Multnomah County Health Department
HIV Grant Administration and Planning
619 NW 6th Ave, 2nd Floor Portland, OR 97209

Standards of Care are the minimum requirements that programs are expected to meet when providing HIV/AIDS care and support services funded by the Ryan White Portland TGA (Transitional Grant Area). Providers may exceed these standards.

The objectives of establishing standards of care are to provide high quality care and support to people living with HIV/AIDS. The establishment of standards of care will ensure programs:

- Provide services that improve health outcomes of people living with HIV along the HIV Care Continuum (also called the HIV Care Cascade) (**Appendix 2**) with the overall goal being viral suppression;
- Provide clients with high quality care through experienced, trained, qualified and, when appropriate, licensed staff;
- Have policies and procedures in place to protect clients' rights;
- Meet federal, state and local requirements regarding safety, sanitation, access, public health and infection control;
- Guarantee client confidentiality, protect client autonomy and ensure a fair process of client grievance review and advocacy;
- Provide services that are client centered, trauma informed and culturally and linguistically appropriate;
- Comprehensively inform clients of services, establish client eligibility and provide equitable access to services;
- Effectively assess client needs and satisfaction with Ryan White funded services;
- Provide coordinated care and referrals to needed services;
- Are accessible to all eligible people living with HIV/AIDS;
- Provide services to historically underserved populations, including but not limited to women, children, youth, transgender and gender non-conforming individuals and people of color. Where data are available it is expected that services will be provided to these populations at least in proportion to their representation in the TGA's estimated HIV prevalence demographics;
- Incorporate harm reduction principles whenever possible;
- Ensure clients apply and receive services that are free of discrimination based on race, color, sex, gender, ethnicity, national origin, religion, age, class, sexual orientation, housing status, and physical or mental ability.

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Ryan White Planning Council Program Guidance

The following document outlines the current HRSA Ryan White (RW) program service definitions for all HRSA RW service categories and the Portland TGA Planning Council guidance for the services funded within the Portland TGA in FY23-24.

FY 23-24 General Planning Council guidance includes:

1. Recognizing that historical and current systems of inequity have resulted in disparities in health outcomes for Black, Indigenous, and People of Color (BIPOC) and other underserved populations, providers must examine processes and procedures in order to evaluate the impact of their practices on the experiences of BIPOC clients, and their health outcomes. Providers will utilize available data, quality management, and client feedback mechanisms to provide direction for system change to improve the experiences and outcomes of BIPOC clients. This includes collecting and reporting data on BIPOC subpopulations, and how the provider or system is addressing the existing disparity for each. Clients and especially BIPOC clients must be included in quality improvement efforts.

2. Services must be provided to historically underserved populations, including but not limited to women, children, youth and people of color, at least in proportion to their representation in the TGA's estimated HIV prevalence demographics.

3. Services must be provided to clients in all counties in proportion to their representation in the TGA's estimated prevalence demographics, except where stated in specific service category guidance.

4. Preference in service delivery should be given to providers that demonstrate the ability to leverage other sources to enhance funded services, and develop working relationships with non-Ryan White funded providers.

5. Providers will coordinate services and refer to other Ryan White service providers, whenever appropriate.

6. Service providers will prioritize interventions that increase client retention at all states of engagement in the HIV Care Continuum. Clients experiencing disparities, including housing, will be empowered to utilize self-management to access necessary services and improve health outcomes.

7. Service delivery will use harm reduction principles, a set of practical strategies and ideas aimed at "meeting people where they are" and reducing negative consequences of a specific behavior, when applicable.

8. Ryan White services shall be effective, linguistically appropriate, fully understandable by the client, trauma informed, and respectful of the client's beliefs. Providers will **practice cultural humility** when providing services to clients of all socio-economic backgrounds, all races and ethnicities, all educational levels, all sexual orientations, all ages and all genders – including transgender or gender non-conforming individuals.

9. Attempt to increase availability of RW services during evenings and weekends or justify why not possible.
10. Clients shall not be asked about immigration status as part of Ryan White eligibility determination.
11. Ryan White providers shall seek client input when making policy decisions.
12. **Outpatient/Ambulatory Medical Care:** All general guidance. Medical care providers must provide coordinated care and implement and monitor strategies to support patient centered medical homes.
13. **Oral Health Care/Dental Care:** All general guidance. Sub-recipient will work to ensure equity of access to dental care for residents of all counties of the TGA.
14. **Early Intervention Services:** All general guidance. Services for newly diagnosed will be tailored to address needs found in current HIV incidence data.
15. **Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals:** All except #1 and #2. Health insurance assistance is based on local needs where other resources are not available. For example, the Portland TGA allocates funds to Clark Co., WA specifically because Oregon's ADAP program (CAREAssist) provides some services not currently provided by Washington's ADAP (Early Intervention Program EIP). Assistance is provided to any Clark Co., WA resident that needs additional health insurance payment assistance, meets eligibility, and pending funds are still available.
16. **Mental Health Services (includes peer programs):** All + Services must address dually diagnosed clients (mental illness and substance abuse) in their service delivery model. Sub-recipient will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors.
17. **Medical Case Management (MCM), including Treatment Adherence Services** All general guidance. Coordinate client linkage to transportation services. Service will develop and utilize client self-management models to better support client access to necessary services and improve health outcomes. Medical case management services must coordinate and engage clients in support programs, including housing, to improve health outcomes of those with multiple diagnoses. Sub-recipient will work to provide support for integration of case management programs into medical care (support medical home model).
18. **Substance Abuse Treatment – Outpatient (includes peer programs)** All general guidance. Services will be provided to clients who are uninsured, underinsured, or are insured but cannot access treatment within a reasonable amount of time and distance. If clients are also in alcohol and drug free housing, Substance Abuse treatment should coordinate with those services.

19. **Housing Services** – All general guidance. Coordinate between HOPWA and Part A programs. Prioritize services that assist clients to access and preserve permanent housing. Services to clients living outside of Multnomah County must constitute a minimum of 20%. Service delivery model will support BOTH leveraged housing units and direct housing assistance to engage the highest possible number of clients in stable housing. Housing options must include access to alcohol and drug free housing. Housing services must be coordinated with core services (specifically early intervention services, mental health care, substance abuse treatment and medical care) whenever possible. Housing case management services may include services to develop housing readiness.

20. **Psychosocial Support Services** - All general guidance, except #2. Efforts should be made to improve access to services for people in outlying areas. Services shall be coordinated with medical case management. The sub-recipient will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors. As part of psychosocial support services, services shall be offered to support clients who have multiple diagnoses.

21. **Food Bank/Home Delivered Meals** – All general guidance.

22. **Non-Medical Case Management** - All general guidance. Services will include addictions benefits coordination services. Services must be coordinated with medical care

23. **Emergency Financial Assistance** – All general guidance.

This guidance is applicable to all funded service categories, except where indicated.

Standard Program Conditions

All providers should follow the minimum care standards outlined in this document. In addition, providers shall comply with all state and local laws, ordinances, and rules governing the jurisdiction in which they practice. Providers shall strive to meet and exceed the benchmarks, targets and national goals outlined in their contracts which are aligned with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) performance measures.

Client Eligibility

Provider shall act as a [second or third] tier agency in determining eligibility for the Ryan White Portland Transitional Grant Area (TGA). CAREAssist is the first tier within the shared eligibility system. Provider will determine Ryan White eligibility and upload supporting documents into CAREWare for all clients receiving Ryan White services with Provider who have not been determined eligible by CAREAssist. Provider shall determine Ryan White eligibility for new clients entering the Portland TGA system and complete redetermination for eligibility annually for existing clients whose eligibility has not been determined by CAREAssist. Provider shall track eligibility redetermination due dates and conduct outreach to clients approximately thirty (30) days before eligibility determination is due. Provider shall

follow eligibility determination process and procedures determined by the County that can be found on the Ryan White Portland TGA Contractors' Site at https://sites.google.com/multco.us/ryan-white-portland-tga.

Provider shall attend eligibility workgroups and/or trainings scheduled by the County to ensure they are up to date with most recent eligibility requirements and procedures. Provider shall have an improvement plan if eligibility completeness in CAREWare falls below 95%.

Providers may use RW funds to provide services to individuals who may be self-referred or referred by case managers, outreach workers, health departments, or other community agencies, and:

1. Have medically verifiable HIV disease.

2. Reside in the six-county Transitional Grant Area (TGA), which consists of the following counties: Clackamas, Columbia, Multnomah, Washington, and Yamhill Counties in Oregon, and Clark County, Washington. Provider shall inform clients that any change in residence must be reported to the provider. Provider shall collect residency information from the client at least annually.

3. Have an income which is less than or equal to 300% of the Federal Poverty Level, unless receiving only Medical Case Management or Early Intervention Services. Provider shall inform clients that any change in income must be reported to the provider. Provider shall collect income information from the client at least annually. While clients receiving services under Early Intervention Services and Medical Case Management are exempt from income requirements they are required to report income.

4. Provide documentation of eligibility that meets standards established by HRSA and the County. HIV Grant Administration and Planning will conduct chart reviews to determine if provider has required documentation. The provider shall document the following:

    a. Identity
    b. HIV Status
    c. Residence in the TGA
    d. Insurance coverage
    e. Income
    f. Eligibility determination status

Indicators

1. Documentation

    a. Client records shall include uploaded documents in CAREWare for shared eligibility. Required documents uploaded in CAREWare include documents that establish proof of residence, proof of income eligibility, and insurance status/proof of insurance annually.

Documentation of HIV status and proof of identity only needs to be established at service initiation.

b. Provider attendance via sign in sheets or registration for webinars at Eligibility Workgroups and trainings facilitated by HIV Grant Administration and Planning (HGAP).

c. Improvement plan or work plan if complete/correct eligibility determinations fall below 95%.

2. Procedures

   a. Providers shall have an established and documented procedure for initial, annual, and midyear eligibility determination.

   b. HGAP will have an established and documented procedure for documenting eligibility within a shared system for the Portland TGA.

   c. HGAP will conduct an annual chart audit based on HRSA program guidance and Portland TGA established standards.

3. Resources

   a. See Contractors' Website for updated documentation standards and HCS procedure manual. https://sites.google.com/multco.us/ryan-white-portland-tga

   b. Attachment 1-FY19-20 Sample Services Contract

Use of Funds

1. Providers shall make reasonable efforts to ensure that clients first use other available resources so that Ryan White Care Act funds are funds of last resort. If the provider utilizes Ryan White grant funds for client services that are eligible for third party reimbursement (e.g. Medicaid, Medicare), they must have a system in place to bill and collect from the appropriate third party payers.

2. If provider delivers Medicaid eligible services through this contract, provider must be Medicaid certified.

3. Clients that are eligible for services from the Veterans Health Administration or Indian Health Service may also be eligible for services. Eligibility for services from the Veterans Health Administration or Indian Health Service shall not be considered in the "payor of last resort" requirement.

4. Funds received through a Ryan White contract cannot be used to make direct financial payments to clients.

5. Provider shall screen clients for access to a primary medical care provider and to health insurance. Where indicated, provider shall link clients with an appropriate service provider or system to facilitate access to medical care. Provider shall link clients, as appropriate, to other services available within the TGA.

6. The following projects and activities are NOT allowable using Ryan White funding:

    a. epidemiological projects,
    b. research studies,
    c. capital projects,
    d. purchasing or improving land, or the purchasing, constructing or permanent improvement of any building or facility, cash payments to service recipients,
    e. cash payments to service recipients including cash equivalent pre-paid cards or vouchers,
    f. clothing,
    g. employment readiness programs and services,
    h. funeral or burial expenses,
    i. non-targeted marketing promotions, advertising about HIV services that target the general public or broad-scope awareness activities that have HIV services that target the general public,
    j. entertainment costs, including the cost of amusements, solely social activities and related incidental costs,
    k. foreign travel,
    l. fundraising expenses, and
    m. lobbying expenses.

Indicators

1. Documentation

    a. Client records shall document efforts made to use other available resources.

    b. Providers shall have an established assessment tool to screen clients for other resources available such as billable insurance or income.

    c. Provider records shall document enrollment for other 3rd party payers such as Medicaid and Medicare.

2. Procedures

    a. Providers shall have an established and documented procedure for billing and collecting from appropriate third party payers when available.

    b. Providers shall have an established system for assessing payor of last resort.

    c. Providers shall have an established system for referring clients to resources and benefits for which they are eligible. Specifically, providers shall refer all uninsured clients to

Application Assisters, CAREAssist, or Medical Case Managers for assistance in getting health and dental insurance coverage.

3. Resources

    a. Attachment 1-FY19-20 Sample Services Contract

    b. HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Sub-recipients - Fiscal https://hab.hrsa.gov/sites/default/files/hab/Global/fiscalmonitoringparta.pdf

    c. HRSA Policy Clarification Notice 16-02-Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters

    d. HRSA Policy Clarification Notice 21-02 Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

Client Confidentiality, Rights and Responsibilities & Provider Responsibilities

1. Providers shall have a written grievance policy and procedure in place that allows clients to express concerns and/or file complaints if they are dissatisfied with the services provided. All funded providers shall submit a copy of their grievance policy and procedure to the County on an annual basis and update as appropriate. Providers shall inform clients about the grievance policy and procedure, and post it where clients can see it.

2. Providers are responsible for notifying HGAP of any formal grievance filed against the agency by a Ryan White funded client. Grievances must be reported at a minimum on quarterly narratives submitted to HGAP with confidential information deducted as applicable. Escalated grievances may be reported to HGAP upon occurrence.

3. Providers shall protect client confidentiality in accordance with state and federal laws and will have a system for safeguarding client information.

4. Providers shall inform clients of their rights and responsibilities and have clear written procedures to maintain client confidentiality.

5. Staff and volunteers shall receive training on confidentiality and HIPAA rules and procedures.

6. Staff and volunteers will sign a confidentiality statement.

7. Providers shall secure, and update, releases of information, in accordance with Federal and State laws, from each person enrolled to allow the provider to communicate, on a need-to-know basis, with external agencies.

8. Providers shall be solely responsible for CAREWare data security at its own agency. Providers shall protect client confidentiality in accordance with state and federal laws, including the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A of the American Recovery and Reinvestment Act of 2009, and the regulations promulgated there under (collectively, "HIPAA").

9. When obtaining an authorization, consent or release of information, provider is responsible for notifying clients that their Ryan White eligibility and service information will be entered into CAREWare and how data will be used.

10. Providers shall be solely responsible for training all Ryan White funded staff on the use of CAREWare and on all security measures pertaining to access, use, and transfer of client data.

11. Providers shall be responsible for maintaining a secure data system, whether it be CAREWare or another system of record, to ensure timely submission of required data and reports.

12. Each HIPAA covered entity participant must:

    a. Separately maintain and provide a notice of privacy practices to clients as required under HIPAA.

    b. Comply with its own obligations under the HIPAA Privacy Rule with respect to the use and disclosure of protected health information.

13. The parties acknowledge and agree that all Confidential Information disclosed by them pursuant to the Contract or the CAREWare Data Sharing Agreement, or made accessible through the use of CAREWare, is confidential. The parties will not use any Confidential Information during the term of the Contract or thereafter for any purpose other than as expressly permitted or required under the Contract or the CAREWare Data Sharing Agreement. The parties will not disclose or provide any Confidential Information to any third party, except as expressly authorized by the Contract or the CAREWare Data Sharing Agreement, or as strictly required by applicable law, regulation, or court order.

14. Providers are responsible for notifying the COUNTY of any breach of confidentiality.

Indicators

1. Documentation:

    a. Personnel records shall contain signed confidentiality statements.

b. Client records shall contain current releases of information, as appropriate.

c. Client records shall document that clients were informed of their rights and responsibilities.

d. Client records shall contain documentation that client was informed about the grievance policy and procedure.

e. Grievance policy and procedure shall be posted in areas accessible to clients such as lobby, clinic rooms, or client meeting rooms.

f. Ryan White funded providers have signed the CAREWare Agreement, and maintain appropriate user documentation, including closing accounts when staff leave the agency.

2. Procedures

   a. Providers shall have an established and documented procedure for maintaining client confidentiality.

   b. Providers shall have an established and documented procedure for filing a grievance. This procedure should be posted where all clients can see it.

   c. Providers shall have an established and documented procedure for maintaining client records according to all state and federal laws governing personal health information.

   d. Providers shall have language included in confidentiality statements, release of information, or rights and responsibility documents that notify clients that their information is entered and shared in CAREWare.

   e. Personnel procedures shall include a staff/volunteer training schedule for client confidentiality and HIPAA training.

3. Resources

   a. Attachment 1-FY19-20 Sample Services Contract

   b. Attachment 2-HIPAA Business Associate Agreement

   c. Attachment 3 - CAREWare Agreement

Safety for Staff and Clients

1. Providers are responsible for the conduct of their staff and volunteers and shall take reasonable measures to ensure the safety of clients.

2. Provider promotes and practices Universal Precautions including Universal Precautions for trauma exposure.
3. Staff are trained on personal safety issues: TB, HIV, Hepatitis infection precautions and management of potentially dangerous situations. Staff will receive blood borne pathogen training.
4. Supervisors shall be advised when staff make home or field visits or transport clients to ensure safety.
5. Clinical services shall meet federal, state and local requirements regarding safety, sanitation, access, public health and infection control.
6. Providers shall provide services in a trauma informed manner. Staff shall be trained in trauma informed practices. This includes vicarious trauma training and support for staff.
7. Providers shall provide services using a harm reduction framework and ensure staff are trained in harm reduction, risk reduction, and prevention counseling practices.
8. Providers shall be trained on suicide threat protocol. Providers shall have immediate access to crisis counseling services such as the Mental Health/Crisis Hotline.
9. Providers shall be trained on providing resources and referrals to clients for domestic violence threats.
10. Providers shall refer clients to other providers if services are restricted. Providers shall provide a timeline for how and when a client can access services in the future with the exception of egregious incidents.

Indicators

1. Documentation
    a. Personnel records contain documentation that staff are trained in Universal Precautions and personal safety issues.
    b. Attendance at Trauma Informed Care training held by HGAP or other providers.
    c. Personnel records contain documentation that staff are trained in harm reduction, risk reduction, and prevention counseling.
    d. Providers shall have a trauma informed implementation plan and/or conduct an organizational assessment of trauma informed practices.
    e. Clinical services personnel records shall contain documentation that staff are trained in infection control protocols.

f. Providers shall have a protocol for addressing suicide threats and personnel records shall document that staff are trained on the protocol.

g. Providers shall have a protocol for screening for and providing resources for people in domestic violence situations when appropriate and personnel records shall document that staff are trained on the protocol.

2. Procedures

   a. Providers shall have an established and documented procedure for tracking staff location during home or field visits.

   b. Providers shall have a procedure in place that provides on-going training and assess staff needs on safety measures applicable to services provided.

   c. Providers shall have an established and documented procedure for transporting clients in vehicles if applicable to services.

   d. Providers shall have a suicide threat protocol within their personnel policies.

   e. Clinical services shall have an infection control protocol.

   f. Providers shall have a suspension/restricting services policy and procedure that includes information about how clients may again access services.

3. Resources

   a. See Appendix 1 Definitions

   b. Revised OARs 309-018-0100, 309-022-0100, and 309-019-0100

   c. http://traumainformedoregon.org/

   d. https://traumainformedoregon.org/resources/resources-organizations/

Quality Management Program

1. Multnomah County HGAP will work with providers to ensure compliance with these Standards of Care and standard contract conditions on an annual basis.

2. Clinical quality outcomes are established by Multnomah County Health Department, the Portland TGA Sub-recipient, and are based on the National HIV/AIDS Strategy goals and standards of care established in this document. Outcomes are targets to strive towards. If outcomes are not met, the expectation is to establish a goal to improve the outcome and

carryout quality improvement (QI) activities. If outcomes are met or exceeded, the expectation is to remain stable.

3. Providers shall have a documented one or three year clinical quality management plan to assess the quality of care provided, to ensure that deficiencies are identified and addressed, and to identify areas for improvement. This clinical quality management plan (CQM) shall be reviewed and updated annually.

4. Quality improvement projects must be focused on improvement of health outcomes along the HIV Care Continuum. QI projects cannot be administrative in nature for the purposes of the CQM Plan. Providers shall use a Plan Do Study Act (PDSA) model for improvement for reporting projects to HGAP.

5. Providers will provide data to the Sub-recipient for contract monitoring, service system development and quality management.

6. Providers shall provide a mechanism for informed community members and persons living with HIV to have meaningful input into the development and implementation of policies and programs designed to address their needs. Providers shall inform clients of opportunities for such input.

7. HGAP will conduct a biennial client satisfaction survey for each service category and share results with the respective provider.

8. HGAP will provide technical assistance as needed or by request and will conduct quality management trainings during the Providers' meetings.

9. HGAP will provide performance measures related to standardized health outcomes such as medical engagement and viral suppression data to providers as available.

Indicators

1. Documentation

    a. Provider records shall contain a clinical quality management plan (and/or annual updates) and two quality improvement reports.

    b. Provider shall review the monthly service utilization reports that HGAP sends to providers on a monthly basis. Any inaccuracies must be reported within 30 days of receipt of the report.

    c. Provider attendance at Providers' Quarterly Meetings & Agenda

2. Procedures

    a. Providers shall have an established and documented procedure for community members and consumers to provide input into provider policies and programs.

3. Resources

    a. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

    b. Attachment 1-FY19-20 Sample Services Contract

    c. See Providers' Website for updated CQM Plan and QI report templates. https://sites.google.com/multco.us/ryan-white-portland-tga/contract-monitoring/quality-management

HIV Care Coordination

1. Since the focus of Ryan White funds is to provide primary health care and support services which enhance access to and retention in medical care, all providers shall coordinate services with client's primary medical provider to the greatest extent possible.

2. Providers shall screen clients for engagement in primary medical care and enrollment in health insurance. Where indicated, providers shall link clients with early intervention services, application assisters, or medical case management for assistance linking to insurance and/or medical care.

3. Medical Case Managers shall be primarily responsible for coordination of care, when possible and with client consent. This lead role of MCM's will allow for an effective and efficient flow of information that will benefit the client.

4. Providers shall assist clients in applying for CAREAssist when appropriate for additional financial assistance with medical and dental insurance coverage. Additionally, CAREAssist will determine eligibility for Portland TGA services for clients shared between CAREAssist and the Portland TGA.

5. Providers are responsible for collecting eligibility documentation within a shared eligibility system for clients that access services with them and have not been determined eligible through CAREAssist. Eligibility determination is shared throughout all Ryan White providers for the purposes of easing burden on clients and providers.

6. Providers shall establish referral relationships with community-based agencies where HIV-positive clients might be identified. Examples of these access points include: hospital emergency rooms, substance use disorder treatment centers, detoxification facilities, detention facilities, STD clinics, HIV counseling and testing sites, mental health programs, supportive housing programs, and homeless shelters.

7. Providers shall know and develop relationships with organizations providing other resources available for PLWH/A within the TGA. If a client presents with needs an agency is unable to meet, the provider should have the ability and the relationships necessary to link clients with other services to meet those needs, as appropriate.

8. Providers shall inform persons living with HIV, community organizations, public health agencies, and treatment providers throughout the TGA about their services. Provider contact information should be kept up to date on www.211.org and updated with HGAP for the RW Provider Contact document.

9. Providers shall collaborate with other care providers to establish a coordinated and effective system of care for PLWH/A.

10. Ryan White funded providers shall attend quarterly Contractors' meetings to stay abreast of Ryan White system initiatives and network with other providers.

11. All Ryan White funded providers are part of an Organized Health Care Arrangement (OHCA) as defined under HIPAA (45 CFR 160.103). Through the administration of CAREWare, the County is a Business Associate of each Covered Entity of the Organized Health Care Arrangement participants.

12. Based on provider services offered, providers shall participate on relevant community collaboratives and act as a liaison for the Portland TGA when appropriate.

13. Providers shall provide adequate staff training about Ryan White funded services and organizations for internal staff and external partners. Providers are encouraged to hold regular coordination meetings with other Ryan White funded agencies as deemed appropriate.

14. Providers shall work within the established Portland TGA Viral Suppression Support Project, and attend planning meetings as appropriate for the providers' role within the plan. See **Appendix 3**.

Indicators

1. Documentation

    a. Client records shall contain documented linkage with medical provider and insurance, or referral for access.

    b. Provider's Contract Compliance report indicates that provider has demonstrated how they have informed other providers of their services for PLWH/A.

    c. Provider's Contract Compliance report indicates that provider has demonstrated knowledge of services available for PLWH/A within the TGA.

    d. Provider's Contract Compliance report indicates that providers works collaboratively with other Ryan White Care Providers.

e. Client records shall contain documentation of active referrals.

f. Attendance at quarterly Providers' meetings shall demonstrate coordination of services.

g. Communication (via narrative reports or ad hoc meetings) with HGAP staff regarding community collaboratives outside of the Ryan White system shall demonstrate coordination of care.

h. If applicable, providers shall have memorandums of understanding with other service providers.

2. Procedure

   a. Provider shall have a procedure for screening and referring clients for insurance coverage, engagement in medical care, and other basic needs.

3. Resources

   a. HGAP OHCA Notice visit https://multco.us/services/living-hiv

   b. Attachment 1-FY19-20 Sample Services Contract

   c. Attachment 3-CAREWare Agreement

Diversity, Equity and Inclusion in Service Delivery

The term culturally competent means services, supports, or other assistance that is conducted or provided in a manner that is responsive to the beliefs, interpersonal styles, attitudes, language, and behaviors of individuals who are receiving the services, supports, or other assistance. Services shall be provided in a manner that has the greatest likelihood of ensuring maximum participation in the program involved.

Diversity is the collective mixture of differences and similarities that includes individual and organizational characteristics, values, beliefs, experiences, backgrounds, and behaviors.

Equity demonstrates an understanding of how health inequities and social disparities affect HIV care and treatment.

Inclusion means that all members participate as engaged and equal partners, and diverse input is regularly sought and used.

1. The Portland TGA providers as a whole shall deliver services to minority populations in proportion to their representation in the local epidemic. Specifically, providers shall provide culturally competent services for women, children, youth (13-24 yrs) and racial/ethnic and sexual minority clients. Providers shall target service delivery with the objective to serve

women, youth, transgender and gender non-conforming, and racial/ethnic minorities at least in proportion to their representation in the TGA's estimated HIV/AIDS prevalence. If a disparity with accessing services is found within a service category, a deeper analysis of clients served at each provider will be conducted.

2. Providers shall recruit, retain and promote a diverse staff that reflects the cultural and linguistic diversity of the community.

3. Staff shall receive on-going training and education to build cultural and linguistic competence and/or deliver culturally and linguistically appropriate services.

4. Providers must ensure access to services for clients with limited English skills or limited literacy skills.

5. Providers must comply with Americans with Disabilities Act (ADA) requirements

6. Providers shall include harm reduction as a component of its service delivery. Harm reduction may include motivational interviewing and risk reduction messages to support client's overall health, including their sexual health, or otherwise mitigate the negative health effects of sexual risk taking or drug use.

7. Providers shall adopt and implement the National Standards for Culturally and Linguistically Appropriate Services as relevant to their agency.

8. Providers shall provide interpretation and/or translation services for clients that request them. This includes American Sign Language interpretation.

Meaningful Involvement of People with HIV/AIDS (MIPA) Guiding Principles

- Demand that people with HIV substantially engaged in policy and programmatic decision-making activities that impact our lives and fairly compensated for participation.
- Recognize the important contribution that people with and affected by HIV/AIDS can have in the response to the epidemic as equal partners.
- Create a space within society for involvement and active participation of people with HIV in all aspects of that response.

Indicators

1. Documentation

    a. Personnel records shall contain documentation of attendance to regular and on-going training that is intended to increase cultural competency in service delivery. Regular is defined as one or more trainings per year.

    b. Providers shall demonstrate knowledge of local epidemiology and client demographics. These data will be reported by HGAP to all providers annually.

2. Procedures

    a. Providers shall have an established and documented procedure to assess and address improvements in the cultural competence of staff.

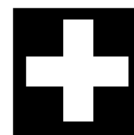
    b. Providers shall have an established and documented procedure for hiring staff that reflects the cultural and linguistic diversity of the community.

    c. Providers shall have a procedure to provide interpretation and/or translation services within a reasonable amount of time when a client requests them.

3. Resources

    a. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

    b. Achieving Reflectiveness: Roadmap to Instill Cultural-Responsiveness as a Life-Long Learning Process in Your PC/PB (Part 2): https://targethiv.org/library/achieving-reflectiveness-roadmap-instill-cultural-responsiveness-life-long-learning-process



Outpatient /Ambulatory Medical Care

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 room or urgent care services are not considered outpatient settings. Allowable activities 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
- 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

HRSA Program Guidance

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 MCM service category.

Portland TGA Programs

Provision of primary and HIV medical care at specialty clinics that follow national standards of care for the treatment of HIV. Care includes diagnosis and treatment of physical and mental health conditions, medication management and adherence counseling, medical care coordination, and referral to other specialty providers and linkage to case management services. Ryan White funded programs must include a Rapid Start component to treatment for people newly diagnosed or re-engaging to care.

Staff Requirements

1. Individual clinicians shall have documented and current unconditional licensure/certification in their particular area of practice.

2. Clinical staff shall be knowledgeable and experienced in their area of clinical practice, and in the area of HIV/AIDS clinical practice. All staff without direct experience with HIV/AIDS shall be supervised or receive consultation by experienced staff.

3. Staff shall maintain up-to-date knowledge of HIV/AIDS treatment protocols and standards of care. Providers, pharmacists, and nurses must adhere to the National HIV Curriculum guidelines.

4. Clients will be informed of any and all treatments, medications, or protocols that are considered experimental and written consent to participate in any experimental treatment will be expressly obtained.

5. Registered Nurses (RN's) must be AIDS Certified Registered Nurses certified by the Association of Nurses in AIDS Care.

6. HIV Providers and pharmacists must be certified with the American Academy of HIV Medicine.

Indicators

1. Documentation

    a. Personnel records shall contain appropriate licensure / certification documentation.

    b. Personnel records shall contain documentation of successfully completed hours of annual job-related training to maintain knowledge of current HIV protocols, standards and treatment.

2. Procedures

    a. Providers shall have an established and documented procedure to assess appropriate credentials during hiring and obtain verification of required renewal licensures, certifications, and continuing education credits.

3. Resources

    a. HIV/AIDS Nursing Certification Board: http://www.hancb.org/Index/index.php

    b. https://aahivm.org/hiv-specialist/

    c. https://aidsetc.org/nhc

Services Standards:

1. Provider/agency shall be accredited/licensed to deliver clinical services and meet Joint Commission guidelines.

2. Clinic services must be provided within an HIV focused patient centered medical home model.

3. At a minimum, outpatient medical care services must be consistent with the most recent publications of: the National Health Institute, Department of Health and Human Services' HIV clinical practice standards, Centers for Disease Control and Prevention (CDC), National HIV AIDS Education and Training Center (AETC), and Public Health Service guidelines for treatment of HIV

infection including Adult, Adolescent, and Pediatric Antiretroviral Guidelines; Adult and Pediatric Opportunistic Infection Guidelines; Sexually Transmitted Diseases Treatment Guidelines, Tuberculosis Screening and Treatment Guidelines in the HIV population, and Perinatal Guidelines.

4. Clinic visits shall be provided to Ryan White eligible clients who either have no insurance coverage, or whose insurance coverage does not cover the services rendered for any reason.

5. Care providers must have systems in place to link potentially eligible clients to other financial resources and programs that cover medical and supportive services, e.g., OHP, CAREAssist and medical case management.

6. Care providers must have systems in place to assist with access to drug therapies.

7. Care providers must develop, implement and monitor strategies to support patient adherence to drug therapy regimens and retention in care.

8. Clients will be actively involved in making decisions about their medical care, having been provided education about potential side effects and benefits of any decision they make.

9. Care providers shall collect risk behavior information at intake and make referrals to HIV prevention education as appropriate on an ongoing basis. Harm reduction strategies will be tailored to the client's needs throughout provision of their health care.

10. Providers will maintain referral relationships with programs where HIV positive individuals may be identified and referred into care (e.g., substance use disorder treatment providers, emergency rooms…). In addition, for those clients who have case managers, primary care providers should maintain communication with their case manager.

11. Providers shall coordinate care with mental health professionals, substance use disorder providers, housing providers, and medical case managers for shared patients as appropriate and within legal parameters.

12. Funded clinics shall have a system in place to accept and schedule newly diagnosed individuals within a maximum of 7 days of receiving a referral or first contact. This includes prescription of ARTs if applicable within 7 days of diagnosis or re-engagement into care.

13. Funded clinics shall coordinate referrals for out of care or newly diagnosed clients from Early Intervention Services programs such as the disease intervention specialist (DIS) and other linkage to care programs.

14. Providers shall provide health literacy assistance when necessary via trained peers, community health workers, case managers, field nursing case managers, or service navigators.

15. Client charts shall be reviewed for preventative care activities, including any health screenings due at the time of scheduled appointments. Reviews shall be tailored based on gender, age, and risk factors using US Preventative Services Recommendations for Primary Care.

16. Provider shall complete regular health screenings for clients seen by a medical provider based on gender, risk factors, and guidance referenced above.

Indicators

1. Documentation

    a. Agency records shall contain evidence of unconditional licensure.

    b. Client records shall contain documentation of client participation and understanding of the plan for his or her medical care. (ORS 677.097)

    c. Intake forms shall contain questions about sexual and drug risk behaviors.

    d. Client records shall contain documented referrals to HIV prevention services as appropriate.

    e. Agency records shall contain documentation of an established relationship between agency and points of access (memoranda of understanding, etc).

    f. Client records shall contain documented referrals to other community HIV Care services when appropriate and documented communication with medical case manager.

    g. Client records shall contain documented date of diagnosis, date of first appointment (within 7 days), and date of first ART prescription (within 7 days).

2. Procedures

    a. Providers shall have an established and documented procedure to monitor compliance with most recent publications of: National Health Institute, Department of Health and Human Services' HIV clinical practice standards, Centers for Disease Control and Prevention (CDC) and Public Health Service guidelines for treatment of HIV infection including Adult, Adolescent, and Pediatric Antiretroviral Guidelines; Adult and Pediatric Opportunistic Infection Guidelines; Sexually Transmitted Diseases Treatment Guidelines, Tuberculosis Screening and Treatment Guidelines in the HIV population; and Perinatal Guidelines.

    b. Providers shall have an established and documented procedure for linking uninsured patients with insurance or other resources to cover medical services.

c. Providers shall have an established and documented procedure for assisting eligible clients with drug assistance programs.

d. Providers shall have an established and documented procedure with established strategies used to support patient adherence to medication regimens.

e. Providers shall have a procedure in place to review patient charts to assess needs for preventative health screenings.

f. Providers shall have a Rapid Start procedure in place to ensure patients that are newly diagnosed or re-engaging in care get access to medications within 7 days.

3. Resources

   a. www.aidsinfo.nih.gov

   b. https://targethiv.org/library/rsr-instruction-manual

   c. http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf

   d. www.cdc.gov/std/tg2015

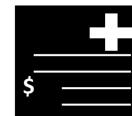
   e. https://www.oregonlegislature.gov/bills_laws/ors/ors677.html

   f. https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

   g. https://www.hiv.uw.edu/

Clinical Quality Outcomes

1. 95% of clients will have at least one VL/CD4 lab during the contract year.
2. 90% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Provider shall be responsible for tracking viral load in CAREWare to be used as shared outcomes across the Portland TGA.
3. 90% of clients will be engaged in HIV medical care defined by at least one medical visit or viral load/CD4 lab value in the first six months (March-August) and at least one medical visit or viral load/CD4 lab value in the second six months (September-February) greater than 90 days apart. Provider shall be responsible for tracking medical appointments in CAREWare to be used as shared outcomes across the Portland TGA.
4. <5% of clients will progress to AIDS.
5. 95% of clients will be prescribed HIV antiretroviral therapy.



Health Insurance Premium & Cost Sharing Assistance

HRSA Definition

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP recipient must implement a methodology that incorporates the following requirements:

- Must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the HHS treatment guidelines along with appropriate HIV outpatient/ambulatory health services
- Must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective.

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of client

HRSA Program Guidance

Traditionally, funding supports health insurance premiums and cost-sharing assistance.

Portland TGA Programs

Health insurance funds pay for health insurance premiums, co-pays and deductibles for clients who live in the TGA. Part A funds in this category are only being utilized for Clark County, Washington residents. CAREAssist through Part B provides similar funds for Oregon TGA clients.

Staff Requirements

Staff must be familiar with eligibility requirements for Medicaid/Medicare and other state insurance programs.

Staff shall receive ongoing training regarding changes in federal and state policies which impact health insurance coverage for PLWH/A in the Portland TGA.

Indicator

1. Documentation

    a. Personnel records shall contain documentation that staff have experience working with or have received training to provide necessary knowledge of Medicaid, Medicare, private insurance options offered on and off of the federal marketplace, and Washington State's AIDS Drug Assistance Program (ADAP) referred to as Early Intervention Program (EIP).

    b. Personnel records shall contain documentation that staff receive regular and periodic training of changes to federal or state policies which impact health insurance coverage for PLWH/A served.

Service Standards

1. The health insurance program shall provide co-payments or premium payments for insurance for low-income PLWH/A who would otherwise be unable to pay these costs to continue their medical and prescription drug needs. Focus of the program shall be on continuous coverage for the maximum number of PLWH/A.

2. Eligibility guidelines shall be documented and available in English and Spanish.

3. Medical case managers shall monitor health insurance coverage and coordinate with ADAP, Insurance Application Assisters, or other federal/state insurance programs when appropriate. Changes in eligibility criteria, program policies and/or program capacity shall be shared with clients within a timeframe that ensures clients will not lose coverage. .

4. Planning Council Guidance: Health insurance assistance is based on local needs in which other resources are not available. For example, the Portland TGA allocates funds to Clark Co., WA specifically because Oregon's ADAP program (CAREAssist) provides some services not currently provided by Washington's ADAP (Early Intervention Program). Assistance is provided to any Clark Co., WA resident that needs additional health insurance payment assistance, meets eligibility, and pending funds are still available.

Indicators

1. Documentation

    a. Client records shall contain documentation of client eligibility, health insurance policy enrollment information, premium expenses and accurate records of when payments were made.

    b. Client records shall contain documentation of referrals to Application Assisters or other insurance assistance programs when clients present as uninsured or underinsured.

c. Eligibility criteria shall be posted online or provided upon request in English and Spanish.

d. Case notes must include documentation that all other funds/resources were exhausted and that clients are not eligible for other assistance through insurance or EIP.

Clinical Quality Outcomes

1. 95% of clients will have at least one VL/CD4 lab during the contract year.

2. 90% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

Mental Health Services

HRSA Definition

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

HRSA Program Guidance

Mental Health Services are allowable only for HIV-infected clients.

Portland TGA Programs

Portland TGA programs provide mental health assessment and individual counseling on-site or at-home, couples or group counseling, and medication management for PLWH/A. Mental health services, including Assertive Community Treatment model services, are delivered by mental health professionals (psychiatrists, psychiatric nurse practitioners, licensed social workers, or licensed professional counselors). Mental health peer wellness specialists support engagement and support for clients accessing professional mental health services.

Staff Requirements

1. Mental health services are provided by a licensed mental health professional or by a Qualified Mental Health Professional as defined by Oregon Administrative Rules or Washington Administrative Code (i.e. psychologist, psychiatrist, psychiatric nurse practitioner, clinical social worker or licensed professional counselor). Peer mentor services must be provided by a Qualified Mental Health Associate as defined by Oregon Administrative Rules.

2. Peer Support Specialists must complete Division approved training as required by OAR 410-180-0300 to 0380.

3. Clinical staff shall be knowledgeable and experienced in working with people living with HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by qualified and experienced staff.

4. Providers shall maintain up-to-date knowledge of HIV/AIDS treatment and the possible effects of HIV/AIDS or its treatments on clients' mental health.

5. Provider shall provide supervision of personnel [as defined in OAR 309-019-0130 and Washington Administrative Code (WAC) 388-877-0200 and include documentation of two hours per month of supervision for each person supervised. The two hours must include one hour of

individual face-to-face contact for each person supervised, or a proportional level of supervision for part-time program staff.

Indicators

1. Documentation

    a. Personnel records shall contain appropriate licensure or certification.

    b. Personnel records shall contain resumes/applications for employment that reflect requisite experience.

    c. Personnel records shall contain documentation of successfully completed hours of job-related HIV/AIDS related training for all providers.

    d. Supervision records shall document two hours per month of supervision for each supervised staff.

2. Procedure(s)

    a. Providers shall have an established and documented policy that requires supervision of staff without direct experience with HIV/AIDS by a supervisor with HIV/AIDS specific training/experience.

    b. Providers shall have an established and documented policy that requires appropriate supervision of QHMP and QMHA.

    c. Providers shall have an established and documented procedure for the regular review of client records by a supervisor.

3. Resources

    a. Oregon Health Authority, Health Systems Division: Mental Health Services, Oregon Administrative Rules: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_019.html
    b. Washington State Legislature, Washington Administrative Code, Outpatient Mental Health Services: http://apps.leg.wa.gov/wac/default.aspx?cite=388-877A

Service Standards

1. Agencies providing mental health services funded by Ryan White funds must have the ability to bill Medicaid for services to clients in the state in which services are provided.

2. All mental health services provided in Oregon shall be provided in accordance with Oregon Administrative Rules governing provision of mental health care. Services provided in Clark County, Washington shall be provided in accordance with Washington Administrative Code.

3. Each client receiving mental health services shall have a mental health assessment and a current treatment plan or action plan with clearly defined goals in the client record. Current treatment plan shall be reviewed and updated annually for clients receiving mental health treatment and every six months for clients receiving peer support.

4. Service provider shall collect risk behavior information at intake and make referrals to HIV prevention education as appropriate.

5. The provider shall coordinate services with clients' primary medical and case management providers, as needed.

6. When appropriate, the provider shall have a written agreement with early intervention services that describes a referral and coordination system between providers to ensure the engagement of clients who are out of medical care or at risk of falling out of medical care due to mental illness or substance use disorder.

7. People living with HIV without insurance and seeking mental health treatment will be referred to qualified Application Assisters and the Peer Mentor program.

8. People living with HIV without access to insurance will be prioritized for mental health services under this contract.

9. The provider shall provide services within the scope of registration or licensure and qualifications.

10. **Mental Health Treatment Services** shall include:

    a. Providers shall provide mental health services, including psychological treatment, psychiatric treatment, and counseling services for clients with a diagnosed mental illness within a time frame consistent with standards of good practice and generally recognized by the relevant scientific community as a timely and effective service to prevent, diagnose and treat the mental health condition. These services shall be conducted in a group or individual setting and shall be provided by a mental health professional licensed or authorized within the State to render such services.

    b. Clients shall be assessed using the questionnaire currently used by Oregon or Washington Medicaid programs (as appropriate) or another approved assessment. Such assessments will be the basis for decisions about the need for continued care.

    c. Mental health treatment services may only include the following activities:

        i. Mental Health evaluation and assessment;
        ii. Individual, couple or family counseling;
        iii. Group counseling;
        iv. Crisis intervention; and
        v. Psychiatric assessment and mental health medication management

d. Provider shall provide Evidence-Based Practices (EBPs) and comply with ORS 182.515 and 182.525. All services must be based on the EBPs accepted by the Substance Abuse and Mental Health Service Administration (SAMHSA) and the State of Oregon or Washington.

e. Provider shall have written discharge criteria. Each client receiving mental health services is required to have a mutually agreed upon Service Plan. Defined by:

   i. Washington: WAC388-877A-0620 as “Each agency licensed by the department to provide any behavioral health service is responsible for an individual’s service plan as follows:

      1. The individual service plan must:

         a. Be completed or approved by professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling services.

         b. Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual’s parent(s) or legal representative.

         c. Be in terminology that is understandable to the individual and the individual’s family.

         d. Document that the plan was mutually agreed upon and a copy was provided to the individual.

         e. Demonstrate the individual’s participation in the development of the plan.

         f. Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.

         g. Be strength-based.

         h. Contain measurable goals or objectives, or both.

         i. Be updated to address applicable changes in identified needs and achievement of goals and objectives.

      2. If the individual service plan includes assignment of work to an individual, the assignment must have therapeutic value and meet all the requirements in (1) of this section.

3. When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both."

4. As per WAC 388-877A-0135, "in addition to the individual service plan requirements in WAC 388-877-0620, an agency providing any outpatient mental health service must ensure the following for an individual service plan. The individual service plan must:

    a. Be completed within 30 days from the date of the first session following the initial assessment.

    b. Be consumer-driven, strength based, and meet the individual's unique mental health needs.

    c. Be initiated with at least one goal identified by the individual or if applicable, the individual's parent or legal representative, during the initial assessment or the first service session following the assessment.

    d. Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual or, if applicable, the individual's parent or legal representative.

    e. Document coordination with any systems or organizations the individual identifies as being relevant to treatment, with the individual's consent or if applicable, the consent of the individual's parent or legal representation. This includes coordination with any individualized family service plan (IFSP) when serving an individual three years of age or younger.

    f. Identify services mutually agreed upon by the individual and provider for this treatment episode."

ii. Oregon: OAR 309-019-0105 (90) as "A comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service." As per OAR 309-019-0140, the provider shall meet the following requirements:

5. Any client who has received three (3) mental health services will have a Treatment Plan completed prior to the next service date.

6. Clients receiving ongoing mental health care must have a new Treatment Plan completed annually, until services are terminated.

7. Treatment Plans shall include all of the following components:

    a. Individualized treatment objectives;

    b. Specific services and supports that will be used to meet the treatment objectives;

    c. Projected schedule for service delivery, including the expected frequency and duration of each type of planned therapeutic session or encounter;

    d. Type of personnel that will be furnishing the services; and

    e. Projected schedule for re-evaluating the Treatment Plan.

11. **Mental Health Peer Mentor Services** shall include:

    a. Services must be provided to PLWH/A for whom mental health services have been suggested, or who have been referred for mental health services but are unwilling or uninterested in following up on that referral immediately. Clients may also self-refer. Clients seeking or in need of substance use disorder treatment only are not eligible for mental health peer services.

    b. Goal plans will be developed in conjunction with the client and updated every six months of service.

    c. Work with clients will be time limited and focused on identifying clients and engaging them in mental health or substance use disorder treatment, as appropriate. Support to clients in the program shall be provided for up to six months or until barriers to engaging in care are resolved or after they are fully engaged in mental health or substance use disorder treatment to allow for problem-solving and support retention in treatment.

12. **ACT model services** shall include:

    a. Services based in service models of Assertive Community Treatment (ACT). Programs that adhere most closely to the ACT model within capacity are more likely to get the best outcomes.

    b. Services must be focused on individuals who frequently use emergency and impatient medical and psychiatric services, are homeless or live in substandard housing, are involved in the justice system; and/or experience substance use disorder.

    c. Services must be highly individualized, combine the interdisciplinary fields that deal with mental illness and substance use disorder, and be provided in community settings. Service activities must include:

i. Crisis assessment and intervention,

ii. Health management and recovery skills,

iii. Referrals to support services around medical care, housing, benefits, and

iv. Transportation assistance to healthcare related appointments

v. Intervention with support networks through the provision of:
    1. Weekly visits
    2. Peer support
    3. Skill development
    4. Counseling

d. Best practice recommends no discharge planning for ACT model services, but program design should include planning for transitioning clients to different levels of care as appropriate.

e. Treatment plans will be developed in conjunction with the client, to be reviewed at a minimum of every six months.

13. Planning Council Guidance: Services shall address dually diagnosed clients (mental illness and substance use disorder) in their service delivery model. The sub-recipient will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors of HIV.

Indicators

1. Documentation

    a. Agency/Personnel records shall contain documentation of agency and provider Medicaid certification.

    b. Client records shall contain a mental health assessment and current treatment plan.

    c. Client records shall contain documentation of sexual risk assessment and referrals to HIV prevention services if appropriate. Intake forms contain questions about sexual risk behavior. Charts document referral to HIV prevention services or onsite HIV prevention services as appropriate.

    d. Client records shall contain information regarding the referrals for treatment for the clients in peer services in order to best provide appropriate services.

e. Client records shall contain a goal plan that was developed in conjunction with client and signed by client and peer mentor.

f. Client records shall contain releases of information for communication and coordination between medical provider and mental health provider and medical case manager. If releases are not possible due to client choice, that should be noted in the file.

g. The type of mental health treatment service provided (i.e. counseling vs peer support) must be documented in CAREWare.

2. Procedure(s)

a. Providers shall have an established and documented procedure for determining Medicaid coverage and billing Medicaid for enrolled clients. Procedure will include referrals for clients who are uninsured/underinsured. Ryan White providers shall bill Medicaid for clients with Medicaid coverage.

b. The provider shall have policies and procedures for credentialing and re-credentialing staff, which include collecting evidence of credentials and verifying the credential. These policies shall include verifying possession of valid licenses or certificates if any are required under any federal, state, or local law or rule, or regulation to deliver covered services.

3. Resources

a. Washington: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

b. Oregon: https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx

c. Oregon Health Authority – Health Systems Division: Behavioral Health Services – Chapter 309

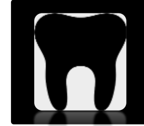
d. Washington State Legislature – Chapter 388-977 WAC Behavioral Health Services Administrative Requirements

e. https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Clinical Quality Outcomes-All Mental Health Services

1. 97% of clients will have at least one VL/CD4 lab during the contract year.

2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.



Oral Health Care

HRSA Definition

The provision of diagnostic, preventive, and therapeutic services provided by general dental practitioners, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

HRSA Program Guidance

None

Portland TGA Programs

Comprehensive dental care provided by practitioners who specialize in treating HIV positive patients. Services include diagnostic, preventative and restorative care, oral surgery and emergency care resulting from pain and infection. Crown and bridge procedures are also provided, with some limitations. Dental navigation services include reaching out to clients and community partners, ensuring that clients are aware of their appointments and services available to them.

Staff Requirements

Participating dentists, dental hygienists, and auxiliaries will possess appropriate license, credentials and expertise as required by the State of Oregon or Washington.

Oral health care providers shall have training in providing care to patients with HIV/AIDS. They shall understand the interaction of HIV/AIDS disease and medications with oral health care. The clinician should be aware that HIV disease and its treatment may be associated with increased risk for dental caries. All participating dentists, dental hygienists and auxiliaries must have at least 4 hours of HIV specific continuing education on a yearly basis. The continuing education curriculum should cover assessment and treatment of persons with HIV as well as cultural competency.

Supervision shall be provided at a minimum according to the most current version of the Oregon Dental Practices Act and Washington Administrative Code.

Indicator

1. Documentation
    a. Personnel records shall contain documentation of current licensure. Forms contain Board of Dentistry license number for all dentists.
    b. Personnel records shall contain documented training/experience in providing care to patients living with HIV/AIDS.

c. Compliance Report indicates that organizational chart documented appropriate supervision.

2. Resources

   a. Oregon Dental Practices Act: https://www.oregon.gov/dentistry/Documents/Dental_Practice_Act.pdf

   b. Oregon Board of Dentistry: https://www.oregon.gov/dentistry/Pages/regulations.aspx

   c. Washington Administrative Code: http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Dentist/Laws

Service Standards

Oral health care services provided shall be in accordance with the standard of care in the community. In addition, due to co-morbidity with HIV/AIDS, the following guidelines shall be followed:

1. Oral health care providers shall use the HIV/AIDS Bureau Oral Health Services performance measures.

2. All people living with HIV/AIDS should have routine examinations by a dentist every six months. Provision of care should be coordinated between medical and oral health care providers.

3. If a patient is not seeing a primary care physician regularly, the patient should be referred to early intervention services or medical case management programs for assistance.

4. The oral health care provider should promptly communicate any clinical findings that may signify a change in the patient's systemic health, or any planned, extensive surgical procedures that may impact the patient's systemic health. A signed consent form shall be obtained from the patient to share personal health information.

5. Every patient should receive a comprehensive initial evaluation which shall include a medical and social history and a comprehensive medical system review. The medical and social history and comprehensive medical review should be performed at each visit for unstable patients and at each recall visit for stable patients.

6. The patient's oral health care provider should review all medications (including naturopathic or homeopathic remedies, or over the counter medications) being used by the patient since HIV-related medications may affect dental treatment and cause adverse effects.

7. In the case of a dental emergency/complication being experienced by a Client; the Client will be called back and scheduled within 24 hours of the inquiry and by the appropriate specialist.

8. Providers shall maintain communication with client's primary care provider.

9. Planning Council Guidance: Sub-recipient shall work to ensure equity of access to dental care for residents of all counties in the TGA.

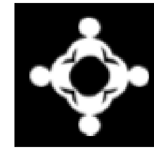
Indicator

1. Documentation
    a. Patient release(s) of information are current and allow communication between the dental provider and other primary care providers.
    b. Client records must include dental procedure, cost of procedure, and amount billed towards Ryan White.
2. Resources
    a. HAB HIV Performance Measures: http://hab.hrsa.gov/deliverhivaidscare/oralhealthmeasures.pdf

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.
2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.
3. At least 75% of unduplicated clients shall receive at least one (1) preventive dental care visit within the contract year.
4. At least 75% of unduplicated clients shall complete a Phase 1 treatment plan within twelve (12) months.

Medical Case Management (MCM), including Treatment Adherence Services & Minority AIDS Initiative



HRSA Definition

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

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

In addition to providing the medically oriented services above, MCM may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare, Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

HRSA Program Guidance

MCM services have as their objective improving health care outcomes whereas Non-MCM Services have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered MCM or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a MCM visit should be reported in the MCM service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Portland TGA Programs

Assessment, coordination of services and linkages to services inside and outside the Ryan White system of care. All medical case management clients receive primary medical case management services which include treatment adherence assessment, health insurance maintenance, and coordinating timely access to appropriate levels of medical and supportive services, through ongoing client assessment. Specialty case management services are also offered in conjunction with primary case management services; this includes nursing case management, and navigation services for Latinx, African-American and refugee/immigrant clients.

In the Portland TGA, Minority AIDS Initiative funding and services are part of the Medical Case Management service category.

Staff Requirements

1. All case managers must have a general knowledge of HIV/AIDS-related conditions and diseases. In addition, case managers shall maintain a comprehensive understanding of the treatment, financial, and support services available to meet the needs of persons living with HIV in the TGA.
2. All staff providing medical case management services will receive orientation and training that covers the following topics (or have documented competency in these areas):
    a. Legal requirements for potential child or elder abuse or neglect and how to report incidents;
    b. Knowledge of local and state resources including insurance, SSA, state disability programs, ADAP (CAREAssist/Early Intervention Program), support services, home health care and long term care
    c. Medication adherence screening
3. Bachelor of Social Work or other related health or human service degree from an accredited college or university; or related experience for a period of 2 years of full time (or equivalent) regardless of academic preparation. Masters of Social Work or equivalent, LCSW highly preferred for both medical case managers and supervisors.
4. Nurse case managers must be licensed registered nurses (RN) within the state of services (Oregon or Washington).
5. Community Health Workers must be certified through Oregon Health Authority's Traditional Health Worker Certification program as available or offered if providing services in Oregon. Community Health Workers providing services in Washington must attend the Washington State Department of Health Community Health Worker Training as available or offered. Staff working within the Minority AIDS Initiative programs are preferred to be Community Health Workers if appropriate.

6. Staff providing guidance around insurance assistance must become Certified Application Assisters through the state in which they provide services. Only certified assisters are allowed to enroll clients in insurance. Staff assigned to provide insurance assistance during open enrollment periods are required to become Certified Application Assisters.

7. Minority AIDS Initiative Service Navigators shall have lived or extensive experience working with the community in which they serve.

Supervision Activities

1. Supervisors shall maintain regular contact with staff and meet with individual staff and with the medical case management team a minimum of once per month.

2. Supervisors shall review a sample of client's care and case records at least once every 90 days.

3. In cases where medical case manager does not have expertise, the supervisor shall provide and arrange for appropriate case consultation by other professionals.

Indicator

1. Documentation

    a. Personnel records shall contain staff resumes that reflect requisite experience and education.

    b. Personnel records shall contain documented completion of staff orientation and training or documented competency.

    c. Personnel records shall contain documented regular supervisory meetings with staff.

2. Resources

    a. Washington: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

    b. Oregon: https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx

Service Standards

Assessment & Eligibility Determination

1. Each prospective client who requires more than information and referrals will be properly screened and evaluated through a brief intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs.

2. Medical case managers shall schedule a comprehensive assessment for clients who require more than information and referrals services within two visits/meetings. The comprehensive assessment will result in the creation of the action plan.

3. No income restrictions exist for clients enrolled in MCM services.

4. Based on the assessment, an action plan shall be created in collaboration with the client. A Any challenges with triaging clients or potential wait-lists should be reported to the Sub-Recipient Office.

5. MCM providers shall act as a second tier agency in determining eligibility for the Ryan White Portland Transitional Grant Area (TGA). CAREAssist is the first tier within the shared eligibility system. MCM provider will determine Ryan White eligibility and upload supporting documents into CAREWare for all clients receiving Ryan White services and that have not been determined eligible by CAREAssist. MCM provider shall determine Ryan White eligibility for new clients entering the TGA system.

6. MCM provider shall complete redetermination for eligibility annually for existing clients that have not been determined eligible by CAREAssist. MCM provider shall track eligibility redetermination due dates and conduct outreach to clients approximately 30 days before eligibility determination is due.

7. Reassessment of needs and delivery of service shall be conducted annually or more often as needed.

8. Provider shall conduct outreach for clients that are not in care either through internal record keeping or from the HGAP provided Not in Care list.

9. MCM's shall screen clients for medication adherence and provide education as needed at a minimum of every six months.

10. Through intake and assessments, MCM providers shall determine client acuity and tailor services and referrals based on acuity as described in the Levels of Need/Service section.

Levels of Need/Service

Recipients should determine their program's acuity levels and case loads. An example of an assessment used to determine the type and intensity of services:

Lowest Need: Client is proficient at negotiating the care system but needs assistance with information and referral.

Low Need: Client needs access to information and possibly initial referral to service(s). Client may need education about services, health issues, medications and other topics. Services could include health literacy and support with maintaining medication adherence. Clients will have an individualized action plan.

Moderate Need: Client needs on-going referrals and case manager follow-up; an individualized action plan will be developed with all clients. Services will be determined by client needs. Contact frequency must be sufficient to ensure implementation and ongoing maintenance of the action plan.

High Need: Client needs on-going referrals and case manager follow-up; an individualized action plan will be developed with all clients. Services will be determined by client needs. Contact frequency must be sufficient to ensure implementation and ongoing maintenance of the action plan. Client should be offered additional support from peers, community health worker, or service navigator. Case management provider should collaborate and be central coordinator for other support professionals.

Coordination of Care/Services

1. Provider shall conduct outreach for clients that have missed medical appointments or have fallen out of care.

2. Establish and maintain referral relationships with early intervention services and other HIV screening and testing providers.

3. Provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible including insurance coverage.

4. Services must be connected and coordinated with HIV medical clinics and other medical case management programs.

5. Services must be client-centered activities focused on improving health outcomes in support of the HIV care continuum.

6. MCM sites shall participate in local Tri-County Early Intervention Services and Outreach planning and coordination. MCM's will be the first level responders for clients that are engaged in medical care but are not virally suppressed and for those clients who were previously connected to a MCM but who have fallen out of care.. Providers shall review client panels monthly at a minimum and conduct appropriate level follow up or response for clients that are not virally suppressed. MCMs shall work with local Disease Intervention Specialists if a client cannot be reached or engaged in care. See **Appendix 3 – Viral Suppression Support Plan**

7. Programs funded through Minority AIDS Initiative shall build and maintain strong relationships with culturally specific, community based programs who work in Latinx, African-American,

and/or refugee/immigrant communities. Services may be subcontracted to community organizations as appropriate.

8. Minority AIDS Initiative Service Navigators shall collaborate with medical case managers, following a shared care/action plan, with consistent communication and case conferences (as appropriate). The navigator may guide clients through the health care system by assisting with access to health care, developing relationships with participating physicians and service providers, patient advocacy, monitoring treatment and outcomes, providing treatment education and adherence, and supporting family members and care givers. Navigators are expected to help clients gain the skills to engage in primary medical care and support services through:

    a. Increasing health literacy, including increased understanding of the health delivery system

    b. Reducing barriers the client may face such as financial, communication, medical system, psychological or other barriers such as transportation and need for childcare.

Planning Council Guidance: Coordinate client linkage to transportation services. Services will develop and utilize client self-management models to better support client access to necessary services and improve health outcomes. Medical case management services shall coordinate and engage clients in support programs to improve health outcomes of those with multiple diagnoses. Sub-recipient shall work to provide support for integration of case management programs into medical care (support medical home model). Provide group and individual case management services in a manner, which increases clients' self-sufficiency and ability to self-manage their disease and co-occurring conditions.

Action Planning

1. Each client will have a brief individualized action plan. The planning process includes the development of goals, assignment of activities to client or CM, referrals and reporting on outcomes. Regardless of client acuity, the action plan will serve as a guide for all service provision including self-management skills training, health literacy evaluation and education and medication adherence support. Appropriate documentation of goals, assigned activities and the outcomes of each will be included in the client's record (paper or electronic), along with any other action planning documents, e.g., housing plan.

2. The action plans will be reviewed, and revised appropriately, at least every six months.

3. Action plans shall be shared with other providers as necessary and deemed by release of information to coordinate care.

Case Closure

1. A systematic process shall be in place to guide transfer of the client to another program, to another staff member, and/or to discharge from medical case management services. The

process includes clear documentation of the reason(s) for transfer, discharge, notifying the client of case closure and the appeals process.

2. Before discharging a client or closing their case, outreach attempts shall be made to assess the client's current acuity level. Clients that are not regularly retained in care shall not be discharged from services until multiple attempts have been made to contact the client and/or outreach is referred to DIS if appropriate. Clients shall be referred and linked to appropriate services before discharging them from services if possible and desired by client.
3. Lowest need clients will become inactive if no contact is made with the client in the previous 12 months. Closure will occur only after review of medical records confirm they are insured, engaged in care, and virally suppressed. Once determined that the client is insured, engaged in care, and virally suppressed then it is appropriate to close them out without contacting them. If those were not true for the client, then outreach either by MCM or DIS/EIS would be appropriate. (See Appendix 3 – Viral Suppression Plan) These clients may become active again after client initiates contact and a reassessment has been conducted.

Indicator

1. Documentation

    a. Client records shall contain all appropriate intake elements including all documents necessary to determine eligibility.

    b. Client records shall contain client's current assessment. Reassessments are documented and dated in client charts.

    c. Client records shall document needs that were discussed and services provided.

    d. Client records shall contain a signed copy of the individualized action plan and complete documentation of action planning and evaluation of the goals in all medical case management client records. The client's individualized action plan will be updated every six months excluding clients that only receive less than two units of service for information and referrals

    e. Client records shall contain current ROIs.

    f. Client records shall contain documentation of appropriate referrals.

    g. Client records shall contain reassessments and updated acuity scores or service needs.

    h. Client records shall contain a transfer/discharge summary cases where client has been transferred or is no longer eligible for services.

    i. Client records shall contain a medication adherence screen and appropriately related action plan updated at a minimum every six months.

2. Procedure(s)

    a. Providers shall have an established and documented procedure for transferring and discharging clients who are no longer eligible for services.

    b. Providers shall have an established and documented procedure in place for determining client acuity and service needs, and the process shall be used consistently across all MCM's at the agency.

2. Resources

    a. Appendix 3 –Viral Suppression Plan

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.

2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Providers shall be responsible for tracking Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

Early Intervention Services (EIS)

HRSA Definition

This includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV infected. Must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts. HIV testing paid by EIS cannot supplant testing efforts 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
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

HRSA Program Guidance

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. RWHAP recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

Portland TGA Programs

Counseling to individuals with respect to HIV/AIDS, testing, and referrals to medical care, mental health and substance use disorder treatment services, as appropriate, to newly diagnosed individuals and persons who are out of care, including clients transitioning from correctional facilities.

Staff Requirements

Staff shall have knowledge and understanding of the criminal justice system, services for PLWH/A, and medical systems. Staff shall have experience working with people experiencing homelessness, mental health conditions, substance use disorder issues, and developmental delays.

Indicators

1. Documentation

    a. Personnel records contain documentation of completed disease intervention specialist or HIV testing training, as appropriate.

    b. Personnel records contain documented training/experience in working with people with substance use disorder/addiction, issues of poverty, mental illness, developmental delays, and criminal justice system.

Service Standards

1. Eligible clients include out-of-care clients who have not been to primary care physician (who is aware of their HIV+ status) for six months or more. (Being seen in the emergency room is not considered being seen for HIV care, nor is being seen by a primary care physician if that physician is not aware of the client's HIV status) and those who are newly diagnosed.

2. EIS staff make effective referrals with follow-up until the client is engaged and retained in HIV primary care and other services to support retention in care.

3. No income restrictions exist for clients enrolled in EIS services.

4. When a client has been successfully retained in medical care, they will then graduate from the EIS program. If a client is engaged but then not retained, EIS may be called upon to re-engage the client.

5. EIS providers shall participate in local Tri-County Early Intervention Services and Outreach planning and coordination. EIS providers will be first level responders for clients that are newly diagnosed or have fallen out of care. EIS providers will be second level responders for clients engaged in medical care and/or have an assigned MCM but who are not virally suppressed. Providers shall accept referrals from MCM's or other providers and conduct appropriate level follow up or response when a client does not have an established MCM. EIS providers shall work with local Disease Intervention Specialist if a client cannot be reached or engaged in care. See **Appendix 3 – Viral Suppression Plan**.

6. Agencies providing EIS services must establish and maintain referral relationships with medical and social service providers, including but not limited to: public health departments, emergency rooms, substance use disorder and mental health treatment programs, detoxification centers, detention facilities, sexually transmitted disease clinics, homeless shelters, HIV/AIDS counseling and testing centers, community corrections, jails, and federally qualified health centers.

7. The program shall have a strong working relationship with case management programs for people with HIV/AIDS.

8. Early intervention services address HIV prevention needs of clients to support sexual health and reduce the risk of transmission of disease through established referral mechanisms to HIV prevention services in the community.

9. Services provided include outreach and health education/risk reduction related to HIV diagnosis.

10. Services must support clients who are not in HIV medical care by making effective referrals with follow-up until the client is engaged in HIV related medical care and case management, substance use disorder or mental health treatment services. Providers must prioritize clients who have been recently diagnosed or have been out of medical care for longer than six months and who experience barriers to care such as:

    a. Active or recent substance use disorder issues
    b. Active or recent mental health issues
    c. Recent or chronic incarceration
    d. Homelessness or unstable housing
    e. Recent change in income

11. Providers shall have clear and articulated discharge criteria that include achieved outcomes, transition to other services and client self-management. Each client receiving services is required to have a mutually agreed upon action plan. Providers shall meet the following requirements:

    a. Action plans must be built from an intake assessment and the action plan must be developed in conjunction with the client. The action plan must contain quantifiable objectives and expected time lines to accomplish objectives. Action plans must be reviewed at a minimum every six months. If planned objectives do not result in desired outcomes, the action plan should be mutually adjusted and changes documented.

    b. Action plans must include objectives to start or maintain HIV medical care.

    c. Action plans should address HIV prevention needs of clients to support sexual health and reduce the risk of disease acquisition and transmission.

    d. Action plans should be shared with client's medical case manager, medical team and community partners as appropriate.

12. Planning Council Guidance: Services for newly diagnosed individuals shall be tailored to address needs found in current HIV incidence data.

Indicators

1. Documentation

a. Provider’s Compliance Review Report indicates that services are reaching newly diagnosed and out of care clients.

b. Client records contain documentation that demonstrates that client has attended a medical appointment within three months of service initiation.

c. Client records contain action plans updated every six months of services and include dates and client signatures.

2. Resources

    a. Appendix 3 –Viral Suppression Plan

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.
2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.
3. 90% of clients will be connected with a Medical Case Manager as defined by at least one medical case management service within the contract year.

Substance Abuse Outpatient Care

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 abuse disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

HRSA Program Guidance

Acupuncture therapy may be allowed under this service category only when, as part of the substance use disorder treatment program funded under the RWHAP, it is included in the documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable Health & Human Service (HHS) guidance, including HRSA/HAB guidance.

Portland TGA Programs

Substance use disorder (SUD) treatment services are funded to provide more access to outpatient treatment. Substance Use Disorder Peers assist clients accessing professional substance use disorder treatment and provide recovery support based on individual service plans.

Service Standards

1. Planning Council Guidance: Services shall be provided to clients who are uninsured, underinsured, or are insured but cannot access treatment within a reasonable amount of time and distance. If clients are also in alcohol and drug free housing, services shall be coordinated with alcohol and drug free housing programs.

2. Substance use disorder treatment services shall coordinate with the addictions benefits coordinator currently funded with non-medical case management funding.

Substance Use Disorder Peer Support

1. Services must be provided to PLWH who have been referred for substance use disorder treatment or for whom treatment has been suggested. Clients may also self-refer.
2. A comprehensive, individualized service plan must be in place for each client who receives peer services. The service plan must address individual/family strengths and available resources. The plan must also identify goals, barriers to obtaining those goals, steps to overcome the barriers and progress toward achieving goals; and document access to and participation in medical care. Service plans must be updated every six (6) months while engaged in peer support services.
3. Working with clients shall be time limited and focused on identifying clients and engaging them in substance use disorder treatment. Support to clients in the program shall be provided for up to six months or until barriers to engaging in care are resolved or after they are fully engaged in substance use disorder treatment to allow for problem-solving and support retention in treatment.
4. Many services delivered by peers are eligible for insurance (e.g. Medicaid) reimbursement. As Ryan White provides funds of last resort, the proposed program shall bill Medicaid when eligible services are provided.
5. Peers must complete an Addictions and Mental Health Division (AHM) approved training program within the first six months of working within the project.
6. Peers shall provide peer services under the supervision of a qualified Clinical Supervisor as defined by Oregon Administrative Rules OAR 309-019-0105 and/or Washington Administrative Code (WAC) 388-877-0200.
7. PLWH without insurance and seeking substance use disorder treatment will be referred to qualified Application Assisters or Medical Case Management for assistance applying for insurance as appropriate.

Indicators

1. Documentation

   Substance Use Disorder Peer Support

   a. Client records shall contain a substance use disorder assessment and current treatment plan.

   b. Client records shall contain documentation of sexual risk assessment and referrals to HIV prevention services if appropriate. Intake forms contain questions about sexual risk behavior. Charts document referral to HIV prevention services or onsite HIV prevention services as appropriate.

   c. Client records shall contain information regarding the referrals for treatment for the clients in peer services in order to best provide appropriate services.

   d. Client records shall contain a goal plan that was developed in conjunction with client and signed by client and peer mentor.

e. Client records shall contain releases of information for communication and coordination between medical provider and mental health provider and medical case manager. If releases are not possible due to client choice, that should be noted in the file.

2. Procedure(s)

   a. **Substance Use Disorder Peer Support -** The provider shall have policies and procedures for credentialing and re-credentialing staff, which include collecting evidence of credentials and verifying the credential. These policies shall include verifying possession of valid licenses or certificates if any are required under any federal, state, or local law or rule, or regulation to deliver covered services.

3. Resources

   a. Washington: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

   b. Oregon: https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.

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Housing Services

HRSA Definition

Housing Services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

HRSA Program Guidance

RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing Policy 11-01, covering each client receiving short term, transitional and emergency housing services. RWHAP recipients and local decision making planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. The US Dept. of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients consider using HUD's definition as their standard.

Funds cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

Portland TGA Programs

Emergency and transitional housing assistance to PLWH/A and their families. Eviction prevention, rent assistance, medical motel vouchers, information and referral and housing case work enable clients to access and remain in transitional and permanent housing. Alcohol/drug-free housing is also provided for PLWH/A while enrolled in treatment home based recovery program.

Staff Requirements

1. Housing staff must be knowledgeable about HIV/AIDS and the impacts of stable housing on overall health outcomes.
2. Staff must also maintain current information about other housing programs in the Portland TGA including but not limited to HOPWA funded housing.
3. Staff shall have experience with or receive training in dealing with clients with mental illness or substance use disorder issues. Housing support staff shall maintain a comprehensive understanding of the treatment, financial, and support services available to meet the needs of persons living with HIV with special emphasis on the services available to clients with mental health and substance use disorder issues, homelessness and co-occurring physical disorders. Staff shall have training in de-escalation of highly stressful situations.
4. Staff shall have knowledge of local and federal housing and tenant laws.

Indicators

1. Documentation

    a. Personnel records shall contain documentation that staff have received training or have experience with dealing with clients under stress, under the influence of alcohol or other drugs, or dealing with clients suffering from mental illness.

    b. Personnel records shall contain documentation that staff have received training or have experience with other housing and homeless services.

    c. Personnel records shall contain documentation that staff have received training about other local and federal housing and tenant laws.

Service Standards

General Housing Support & Assistance

1. Emergency rent assistance shall be provided to clients who, without assistance, would be unable to gain or maintain HIV-related medical care or treatment. Provider shall require that housing clients establish and maintain medical care as prescribed by their HIV primary care provider.

2. The agency shall require that clients receiving housing assistance have a medical care provider or accept a referral for care. Initial housing payments can be made regardless of current participation in medical care. Subsequent housing assistance requests shall require verification of participation in medical care.

3. Short-term or emergency assistance is understood as transitional in nature and for the purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate,

and ensure the individual or family is moved to, or capable of maintaining, a long-term, stable living situation. In order to provide clients with financial assistance, provider shall document individual client's need by reviewing a housing application completed by the client. Provider shall have established procedures to determine the amount and duration of financial assistance based on actual need to prevent homelessness and availability of funds. Provider shall document household size and composition and that the rent is reasonable and affordable based on the U.S. Department of Housing & Urban Development Standards or local housing authority established rent payment standards.

4. Provider shall provide housing planning meetings (a short assessment and development of a plan that identifies strategies to secure or maintain long-term stable housing) or provide assistance in completing housing applications. Housing plans must be updated every six months for continued housing assistance, both case management services and financial assistance. The housing plan will address individual or family strengths and available resources. The plan will also identify goals, barriers to obtaining those goals, steps to overcome the barriers and document progress toward achieving goals.

5. Action plans for clients must include increasing income for clients that have no income. This may include applying for disability benefits or accessing employment services as appropriate.

6. The curriculum for housing related workshops shall be developed using evidence based models designed to increase client's ability to attain and maintain permanent housing. Workshop curricula include information about tenant/landlord rights and responsibilities, eviction prevention, budget management and housing discrimination.

7. Funded programs shall participate in local housing and homeless services planning such as HUD Continuum of Care committees.

8. Housing casework and medical case management services shall be coordinated; housing plans shall be included in action planning for medical case management clients. At a minimum monthly coordination of shared client panels is recommended.

9. Housing Case Managers shall work with MCM's, EIS providers, or local Disease Intervention Specialists (DIS) if a client is not virally suppressed, cannot be reached, or engaged in care and does not already have an established MCM and conduct appropriate level follow up or response. See **Appendix 3 – Viral Suppression Plan**.

10. Provider shall also conduct outreach to inform persons living with HIV and service providers about HIV and housing issues and services available in the community.

11. Clients that are medically vulnerable or people that are newly diagnosed shall be prioritized for housing services.

12. Planning Council guidance: Coordinate between HOPWA and Ryan White programs. Prioritize services that assist clients to access and preserve permanent housing. Services to clients living outside of Multnomah County must constitute a minimum of 20%. Service delivery model will support BOTH leveraged housing units and direct housing assistance to engage the highest possible number of clients in stable housing. Housing options shall include access to alcohol and drug free housing.

13. Financial housing assistance cannot be used for security deposits.

Allowable Costs

- Current rental payment
- Back or late rental payment
- Current utilities (ongoing)

Allowable Costs	Prohibited Costs
• Current rental payment	• Any client bill that has gone to collections
• Back or late rental payment	• Security deposits
• Current utilities (ongoing)	• Mortgage assistance
• Back or late utilities (one-time)	• Basic necessary furnishing, including beds
• Rental application fees	• Moving assistance and delivery fees
• Program background check	• Truck rental or fuel costs
• Key replacement	• Pet fees, rent or deposits
• Bus tickets, taxi vouchers, and gas cards for housing searches and medical appointments	• Muck out to clean a unit
• Shelter Vouchers – City Team	

Substance Free Housing/Home Based Recovery

1. If providing housing for substance use disorder treatment or substance free housing, the agency shall coordinate housing efforts with the treatment provider and ensure continuity of care.

2. Home based recovery programs shall conduct outreach to other HIV service providers to ensure access to services. Addictions Benefits Coordinator (funded under non-medical case management) shall refer clients to home based recovery programs and ensure beds are utilized at the agreed upon rate.

3. Provider shall provide housing planning meetings (a short assessment and development of a plan that identifies strategies to secure or maintain long-term stable housing) or provide assistance in completing housing applications. Housing plans must be updated every six months for continued housing assistance, both case management services and financial assistance. The housing plan will address individual or family strengths and available resources. The plan will also identify goals, barriers to obtaining those goals, steps to overcome the barriers and document progress toward achieving goals.

Indicators

1. Documentation

    a. Client records must contain current documentation of engagement in medical care or recent referral.

    b. Client records must contain documentation that no client has received more than established financial limitations; if more assistance is provided, there is documentation signed by the Program Manager or designee.

    c. Client records must contain documentation of any extensions of time are signed by appropriate staff. An updated housing plan documents this extension.

    d. Client records must contain documentation of housing planning meetings for all clients.

    e. Client records must contain documentation of housing assessments. For those clients eligible for Ryan White housing, a housing plan shall be developed that includes goals, barriers, a plan to overcome the barriers and documentation of progress.

    f. Client records must contain documentation supporting financial assistance and need for financial assistance in addition to Ryan White eligibility documentation. Documents include a valid lease in the client's name, proof of unit being affordable or rent reasonable, budget or supporting documentation indicating the client can financially sustain the unit, and other documentation supporting need such as late notices, utility bills, etc.

    g. Provider must have a memorandum of agreement with substance free housing if applicable.

2. Procedure
    a. Provider shall have a policy and procedure for clients to apply for financial assistance and an approval/denial process if providing financial assistance.

3. Resources

    a. Policy Clarification Notice 16-02 https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

    b. HUD Fair Market Rent: https://www.huduser.gov/portal/datasets/fmr.html

    c. Appendix 3 –Viral Suppression Plan

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.

2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA. Provider shall be responsible for tracking viral load for clients that are not enrolled in Ryan White funded medical case management programs.

General Housing Assistance & Support

1. At least 90% of clients receiving financial assistance shall be in stable housing six months after their last rental payment.

2. At least 85% of clients receiving community based housing support will be stably housed at the end of the fiscal year.

3. At least 30% of clients receiving clinic-based housing support will be stably housed at the end of the fiscal year.

Substance Free Housing/Home Based Recovery

1. 50% of clients enrolled in home based recovery treatment successfully complete the program, are still enrolled, or transfer to another treatment program. Treatment progress reports shall include:

    a. Treatment completed
    b. Client is still enrolled in treatment
    c. Transferred to another treatment program

Psychosocial Support Services

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. These services may include:

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

HRSA Program Guidance

Funds under this service category may not be used to provide nutritional supplements.

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Portland TGA Programs

Emotional, social and practical support to clients through day drop-in centers, congregate meals and peer support. Psychosocial services are targeted for women, long term survivors, and historically underserved populations – clients who are homeless, clients with multiple diagnoses, and racial and ethnic minorities.

Staff Requirements

1. Staff shall have knowledge of HIV services.
2. Peers shall receive adequate, specialized, and on-going support and training.

Indicators:

1. Documentation
    a. Personnel records shall contain documentation of training and support for peer mentors.
    b. Provider's Contract Compliance Report shall indicate that staff have demonstrated knowledge of Ryan White and other community services.

Service Standards

1. Clients shall be PLWH/A who have additional need for support to maintain or improve their health. Many face isolation, extreme poverty or have multiple diagnoses that necessitate additional support systems.

2. Agency shall assess clients for support services needs, including support needs for adherence to antiretroviral treatment regimens, and develop an appropriate action plan for assessed needs.

3. Agency shall provide referral to early intervention services, medical case management, mental health and substance use disorder treatment as appropriate.

4. Agency shall provide emotional and social support services, including peer support, advocacy, informal counseling, linkage with medical case management, and information and referral.

5. Agency shall comply with federal requirements regarding use of Ryan White funds for recreational and social activities for eligible individuals in adult and child day or respite care centers. Contract funds cannot be used for recreational activities or gym memberships.

6. Link clients to practical support services and basic needs which may include emergency assistance, food bank, clothing, and hygiene supplies.

7. Conduct a support group for women and/or long term survivors living with HIV/AIDS.

8. Provide childcare during center activities for activities/groups in which childcare is needed to support engagement.

9. Group meals and workshops are available for clients with psychosocial needs including but not limited to:

    a. reducing social isolation,
    b. increased linkages with medical and social services,
    c. support for medical adherence,
    d. support for activities of daily living, and
    e. peer support.

10. Group meals and workshops shall be offered in a setting which promotes the development of a support community, where clients are able to meet with other service providers and where health education and risk reduction messages are shared.

11. Efforts should be made to improve access to services for people in outlying areas. Services shall be coordinated with case management. The sub-recipient will work with providers to develop strategies to support people with HIV who are aging and/or are long-term survivors. As part of psychosocial support services, services shall be offered to support clients who have multiple diagnoses.

12. Psychosocial support program sites shall be available to other Ryan White service providers as a location to access and engage clients in services. Programs will host training and education provided by other Ryan White service providers.

13. Information about other services for PLWH/A shall be readily available. Care system staff serving PLWH/A are invited to provide services at the site and training and education programs are made available to clients.

14. If preparing food for congregate meals, the kitchen shall meet State/County inspection standards.

15. Collaborate with consumer groups and other HIV providers to conduct outreach for long term survivor workshops. Transportation assistance shall be provided for anyone experiencing barriers to attend the group.

Indicators

1. Documentation

    a. Client records shall contain assessment of need completed at client intake.

    b. Client records shall contain release of information between provider and medical case management provider, medical provider, mental health and substance use disorder providers as appropriate. Agency has established working relationships with agencies that provide outreach and advocacy, medical case management, mental health and substance use disorder treatment.

    c. Agency records shall contain memoranda of understanding (MOU) with other Ryan White service providers which clearly describe communication and coordination systems.

    d. Agency records shall document compliance with food and kitchen inspection standards if congregate meals are provided.

2. Procedures

    a. Providers shall have a procedure to screen for engagement in medical care and to link clients to early intervention services or medical case management if determined to be out of medical care.

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

HRSA Definition

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

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

HRSA Program Guidance

Unallowable costs include household appliances, pet foods, and other non-essential products.

Portland TGA Programs

This service provides medically necessary home-delivered meals and nutritional supplements.

Staff Requirements for Home Delivered Meals

1. All staff and volunteers who help with food preparation shall have valid food handler cards.

2. All volunteers delivering food by car shall have a valid driver's license and appropriate auto insurance.

3. A background check will be run on all volunteers who may enter clients' homes.

4. All staff and volunteers shall receive training on food safety issues and have current knowledge of the nutritional needs of PLWH/A.

5. Provider shall provide training for staff and volunteers on use of the Food Services manual (see service standards below).

6. A staff person shall supervise the work of all volunteers and the quality of the food prepared.

7. Supervisors shall maintain periodic checks to ensure that staff and volunteers are following the Food Services manual.

8. All staff training history and credentials shall be reviewed, at least annually, by their supervisor.

Indicators

1. Documentation

a. Personnel/volunteer records shall contain copies of current food handler cards for all cooks, copies of valid driver's licenses for all drivers and documentation of background checks.

b. Volunteer records shall contain documentation that all volunteers have received training on food safety, with additional training on the food safety needs of people with HIV disease.

c. Agency records shall contain a schedule with supervisor's signature that indicates that program supervisors have monitored food preparation and storage at least every three months.

d. Personnel records shall contain annual supervisory review.

2. Procedure

    a. Providers shall have an established and documented procedure for training staff and volunteers on the nutritional needs of PLWH/A and the Food Services manual.

    b. Providers shall have an established and documented procedure which identifies a schedule for staff and volunteer supervision and identifies responsible supervisor.

Services Standards

Home Delivered Meals

1. Clients receiving home delivered meals with Ryan White funds shall have a documented medical necessity for receiving the service. Authorizations for the service must be conducted with a case manager, nurse or medical provider by phone, fax, mail, or email at least every six months.

2. Provider may provide nutritional supplements as appropriate, based on the recommendation of a Nutrition Consultant, Nurse or primary medical care provider.

3. The nutritional content of meals shall be consistent with good dietary habits that promote health and reduce risk for major chronic diseases. Menus shall be developed based on guidance from the US Department of Agriculture's *Dietary Guidelines for Americans* (2020-2025). Meals shall be provided that meet the specific nutritional needs of PLWH/A.

4. Provider shall monitor clients' continued need for home delivery and, where indicated, encourage participation in the on-site meal program available through the Day Center program specified in the Psychosocial Support program.

5. Provider shall maintain a Food Services Manual that addresses food service and preparation standards, sanitation, safety, food storage and preparation, portioning and serving meals, and volunteer and driver training.

6. All food preparation and storage shall be provided in accordance with the Food Services Manual.
7. Menus shall be developed that include meals that address a variety of cultural preferences. Programs are responsible for evaluating the cultural appropriateness of meals and providing alternatives as needed.
8. Provider kitchen must meet appropriate State/County inspection standards.

Food Pantry Services

1. Provider shall establish a referral and financial assistance system with local food pantries in Clark County, Washington.
2. Culturally appropriate foods must be made available.
3. In addition to food, personal hygiene items and household cleaning supplies are acceptable items to distribute to clients using Ryan White funds. Paying for pet supplies, cooking supplies, clothing, and office supplies are not allowed.
4. Food assistance is for Clark County eligible residents only.

Indicators

1. Documentation
    a. Client records shall contain referral by primary care physician or case manager, with reassessment of need for home-delivered meals every six months.
    b. Client records shall contain a Release of Information (ROI) with all clients' case managers to allow communication when necessary or document that client declined signing.
2. Procedure(s) for Home Delivered Meals
    a. Providers shall have an established and documented procedure for reviewing nutritional value of meals to assure they are in compliance with US Department of Agriculture's *Dietary Guidelines for Americans* (2020-2025).
    b. Food Services Manual has been developed and maintained and is easily available for staff to consult.
    c. Providers shall have an established and documented procedure for referring clients who recover and no longer need home-delivered meals to group meal services and other food programs in the community.
3. Resources

a. US Department of Agriculture's *Dietary Guidelines for Americans* (2020-2025): https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 lab during the contract year.
2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

Non-Medical Case Management

HRSA Definition

Non-Medical Case Management (Non-MCM) services provide guidance and assistance in accessing medical, social, community, legal, financial and other needed services. Non-MCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacture's Patient Assistance Programs, other state and local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

HRSA Program Guidance

Non-MCM services have as their objective providing guidance and assistance in improving access to needed services whereas MCM services have as their objective improving health care outcomes.

Portland TGA Programs

Non-Medical Case Management services provides addictions benefits coordination for PLWHA wanting to engage in substance abuse treatment, and eligibility and intake services at MCM provider sites.

Service Standards

Intake/Eligibility/Application Assistance

1. Non-Medical Case Management eligibility and intake providers shall act in coordination with MCM providers as second tier agencies in determining and updating eligibility for the Ryan White Portland Transitional Grant Area (TGA). CAREAssist is the first tier within the shared eligibility system. Non-MCM provider will determine Ryan White eligibility and upload supporting documents into CAREWare for all clients receiving Ryan White services and that have not been determined eligible by CAREAssist. Non-MCM provider shall determine Ryan White eligibility for new clients entering the TGA system.
2. Assist in assessment, care coordination, and information and referral.
3. Case management will directly assist with health insurance enrollment activities to ensure client access to medical services and medications. Case Managers shall assist clients in enrolling in

Medicaid, Medicare, employer group and Silver level off-exchange plans. To quality for and maintain ADAP enrollment, proof of insurance coverage must be documented and provided to CAREAssist. When a premium exists or when a premium changes, Agency will provide CAREAssist with a premium statement and auto-enrollment letter.

4. Case Managers shall assist ADAP clients in accessing a CAREAssist preferred pharmacy.

***See* full assessment and eligibility requirements under *Medical Case Management* on Page 42**

Addictions Benefits Coordination

1. Provide care coordination and assist PLWH to appropriate levels of addiction treatment for non-Care Oregon members.
2. Conduct outreach to detox centers, residential treatment facilities and outpatient treatment programs to facilitate referral relationships.
3. Establish a referral system with HIV medical case management programs to accept referrals for treatment coordination.
4. Coordinate efforts with medical case managers or other referring sources to ensure clients are eligible for Ryan White services before initiating services with PLWH.
5. Monitor clients progress in treatment and report outcomes in CAREWare.
6. Provide HIV 101 education and training to at least one treatment provider once a quarter. Training must be based on needs of the Ryan White community or upon request from treatment providers.

Indicators

1. Documentation
    a. Client records shall contain an assessment of needs.
    b. Client records shall contain outcomes of treatment or refusal of treatment.
    c. Provider must have an agenda and participant list of any facilitated trainings.
2. Procedure(s)
    a. Providers shall have a procedure for accepting referrals from medical case managers or other Ryan White providers which includes verifying Ryan White eligibility.

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 during the contract year.

2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

Emergency Financial Assistance

HRSA Definition

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

HRSA Program Guidance

Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance

Portland TGA Programs

Emergency Financial Assistance funds must be limited amounts, limited use, and limited periods of time. Providers shall establish clear standards for access to assistance and a limit for the amount of assistance a client may receive per grant year. Continuous provision of an allowable service to a client should not be funded through Emergency Financial Assistance and should be documented in the client's care plan.

Service Standards

Agencies should have systems in place that account for equitable distribution of EFA goods and services. Gift cards cannot be exchanged for cash or anything other than the allowable EFA goods and services.

EFA VISION CARE

Description:
Services rendered by an Optometrist, Ophthalmologist or Optician not otherwise covered by insurance.
Program Guidance:
This service category includes corrective prescription eyewear once every two (2) years. Contacts are not covered in this service category unless prescribed as medically necessary by a licensed professional

EFA FOOD AND HYGIENE

Description:
A gift card cannot be converted to cash, allowing a client to purchase food products and groceries (including hygiene products) necessary to maintain health for the client with an emergent need in a short-term manner.
Program Guidance:

Documentation that clients have exhausted other food services prior to authorization (i.e. food banks, EBT). The gift card should clearly state that purchase of alcohol and tobacco products are not allowed. EFA funds can also be used to make payments to a store on behalf of a client.

EFA UTILITIES

Description:

A service provided as an essential service to the health and welfare of a client; to include: heat, water, electricity, internet, cell phones, data plans, garbage collection, telephone service, and utility deposits. Cable and satellite television service are excluded.

Program Guidance:

Clients are eligible for EFA utility assistance if:

- They have been assessed as having an emergency need
- They provide current detailed documentation substantiating the amount of the subsidy for the specific utility requested
- The utility bill is current

EFA OTHER

Description:

The provision of short-term payments to assist with other emergency expenses; to include: identification and birth certificates, tents, and sleeping bags.

Program Guidance:

All other EFA expenses should have prior authorization from HIV Grant Administration and Planning.

Staff Requirements

None

Indicators

1. Documentation of emergency need

2. Documentation of issuances with date, time, client name and gift card or item

Clinical Quality Outcomes

1. 97% of clients will have at least one VL/CD4 during the contract year.

2. 92% of clients will be virally suppressed indicated by their last viral load test below 200 copies during the contract year. Ryan White funded medical case management sites shall be responsible for tracking CD4 and Viral Load in CAREWare to be used as shared outcomes across the Portland TGA.

Appendix 1-Definitions

Trauma-informed services: Trauma-informed services are services and supports that are informed about and sensitive to trauma-related issues present in individuals who have experienced trauma. The service system has been reconsidered and evaluated in regard to understanding the impact of trauma in the lives of people seeking mental health and addictions services. A standard of "universal precautions" (see definition) exists where people are assumed to have experienced trauma and treated accordingly, rather than the inverse approach. Service systems accommodate the vulnerabilities of individuals who have experienced trauma, and deliver services in a manner that avoids inadvertent re-traumatization, and facilitates their participation in treatment. Collaboration with other practioners with trauma related clinical expertise takes place. Clinicians and others are encouraged and assisted to address their own vicarious traumatization in working with individuals who have experienced trauma.[1]

Universal Precautions: "Universal precautions" is a term used in medical settings to describe the need to assume all individuals seeking services have been exposed to negative conditions. In trauma informed care, universal precautions means assuming that all individuals presenting for services may have experienced trauma and may have symptoms from this exposure that are not immediately obvious. Some individuals may not be comfortable to disclose or able to recall their trauma. The high prevalence of trauma exposure in the general population and especially in mental health and addictions populations dictates that a universal precautions approach be used.[1]

Vicarious Traumatization: Vicarious trauma is a stress reaction that may be experienced by professionals and peer support specialists who are exposed to disclosures of traumatic images and events by those seeking help. Helping persons may experience long lasting changes in how they view themselves, others, and the world. The symptoms of vicarious trauma are similar to, but usually not as severe as those of posttraumatic stress disorder, and can affect the lives and careers of even those with considerable training and experience in working with disaster and individuals who have experienced trauma.[1]

Health Literacy: the degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions. The concept of health literacy represents a constellation of skills necessary to function effectively in the health care environment and act appropriately on health care information. These skills include print literacy (the ability to read and understand text and locate and interpret information in documents), numeracy (the ability to use quantitative information), and oral literacy (the ability to speak and listen effectively). This can also include a working knowledge of disease processes, an ability to use technology, ability to network and interact with others socially, motivation for political action regarding health issues, and self-efficacy.

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[1] Trauma Informed Services, Policy Number AMH-060-1607, Addictions and Mental Health Division, Oregon Health Authority, version 1.0.

Quality Management Plan: A quality management plan describes all aspects of the CQM program including infrastructure, priorities, performance measures, quality improvement activities, action plan with a timeline and responsible parties, and evaluation of the CQM program. [2]

Quality Improvement: Quality improvement entails the development and implementation of activities to make changes to the program in response to the performance data results. To do this, recipients are required to implement quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction. Recipients are expected to implement quality improvement activities using a defined approach or methodology (e.g., model for improvement, Lean, etc.) Quality improvement activities should be implemented in an organized, systematic fashion. As a result, the recipient is able to understand if specific changes or improvements had a positive impact on patient health outcomes or were indicative of further necessary changes in RWHAP funded services. All quality improvement activities should be documented.[2]

Long Term Survivors: Pre-HAART-First generation survivors are individuals who acquired HIV in the 1980s and 1990s, before advent of highly effective antiretroviral therapy when having HIV was considered a death sentence. It is often called the Plague Years. Those living longest with HIV have physical and psychosocial implications that are vastly different from those who acquired HIV later in the epidemic. Children who were born with HIV or who acquired as children also represent the first generation who are now adults. Post-HAART-Those who tested HIV+ after 1996 when Highly Active Antiretroviral Therapy (HAART) medications turned HIV from death sentence into a chronic manage illness and are living with HIV for over 10 years.[3]

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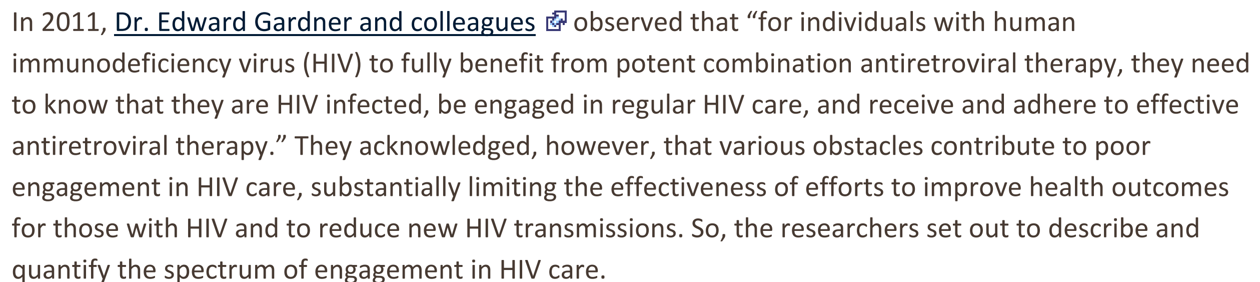
[2] Clinical Quality Management Policy Clarification Notice (PCN #15-02). Accessed at http://hab.hrsa.gov/manageyourgrant/clinicalqualitymanagementpcn.pdf

[3] LetsKickASS.org. https://letskickass.hiv/what-is-aids-survivor-syndrome-dc0560e58ff0

Appendix 2-HIV Care Continuum[4]

Text copied from www.aids.gov.

The HIV care continuum—sometimes also referred to as the HIV treatment cascade—is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage.



In 2011, Dr. Edward Gardner and colleagues observed that “for individuals with human immunodeficiency virus (HIV) to fully benefit from potent combination antiretroviral therapy, they need to know that they are HIV infected, be engaged in regular HIV care, and receive and adhere to effective antiretroviral therapy.” They acknowledged, however, that various obstacles contribute to poor engagement in HIV care, substantially limiting the effectiveness of efforts to improve health outcomes for those with HIV and to reduce new HIV transmissions. So, the researchers set out to describe and quantify the spectrum of engagement in HIV care.

The result of the researchers’ work was the HIV care continuum (or “cascade”), which they defined as having the following stages: diagnosis of HIV infection, linkage to care, retention in care, receipt of antiretroviral therapy, and achievement of viral suppression. Many in the HIV field at the Federal, state, and local levels have since used or adapted this HIV care continuum to better identify gaps in HIV services and develop strategies to improve engagement in care and outcomes for people living with HIV.

In 2013, President Obama established the HIV Care Continuum Initiative, directing Federal departments to prioritize addressing the HIV care continuum as they continue to implement the National HIV/AIDS Strategy, accelerating efforts to better address drop-offs along the continuum, and increasing the proportion of individuals in each stage along the continuum.

Different research studies present the stages of the HIV care continuum in different ways. A November 2014 Vital Signs report published by the Centers for Disease Control and Prevention (CDC) discusses the following stages of the continuum:

- **HIV testing and diagnosis** —The HIV care continuum begins with a diagnosis of HIV infection. The only way to know for sure that you are infected with the HIV virus is to get an HIV test. People who don't know they are infected are not accessing the care and treatment they need to stay healthy. They can also unknowingly pass the virus on to others. CDC recommends that all adolescents and adults be tested for HIV infection at least once, and that persons at increased risk for HIV infection be tested at least annually.

[4] AIDS.gov. HIV Care Continuum. Accessed at https://www.aids.gov/federal-resources/policies/care-continuum/

- **Getting and staying in medical care**—Once you know you are infected with the HIV virus, it is important to be connected to an HIV healthcare provider who can offer you treatment and prevention counseling to help you stay as healthy as possible and prevent passing HIV on to others. Because there is no cure for HIV at this time, treatment is a lifelong process. To stay healthy, you need to receive regular HIV medical care.

- **Getting on antiretroviral therapy**— Antiretrovirals are drugs that are used to prevent a retrovirus, such as HIV, from making more copies of itself. Antiretroviral therapy (ART)is the recommended treatment for HIV infection. It involves using a combination of three or more antiretroviral drugs from at least two different HIV drug classes every day to control the virus. U.S. clinical guidelines recommend that everyone diagnosed with HIV receive treatment, regardless of their CD4 cell count or viral load. Treatment with ART can help people with HIV live longer, healthier lives, and has been shown to reduce sexual transmission of HIV by 96 percent.

- **Achieving viral suppression**—By taking ART regularly, you can achieve viral suppression, meaning a very low level of HIV in your blood. You aren’t cured. There is still some HIV in your body. But lowering the amount of virus in your body with medicines can help you stay healthy, live longer, and greatly reduce your chances of passing HIV on to others.