AIDS INSTITUTE

RETENTION AND ADHERENCE PROGRAM STANDARDS

NYS DEPARTMENT OF HEALTH
AIDS INSTITUTE
DIVISION OF HIV AND HEPATITIS HEALTH CARE
BUREAU OF HIVAMBULATORY CARE SERVICES
REVISED 12/2021

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I. PURPOSE AND INTENT

The Retention and Adherence Program (RAP) provides a range of patient-centered activities, by an interdisciplinary team, focused on improving health outcomes in support of the HIV care continuum. The program's intent is to support and build the capacity of people living with HIV(PLWH) to independently manage their health care and achieve viral load suppression. RAP promotes Undetectable=Untransmittable (U=U) messaging and other anti-stigma campaigns to improve patients' overall health and well-being. The program focuses on individuals newly diagnosed and patients not virally suppressed. The program design requires intensive individualized interventions to minimize barriers to care, facilitate rapid antiretroviral (ART) initiation, and encourage adherence to ART. A primary care clinic infrastructure must be established and maintained; this infrastructure supports Ending the Epidemic (ETE) goals regarding early initiation of HIV treatment, early access to and engagement in HIV care, as well as retention to improve health outcomes. A multidisciplinary team approach is used to provide support for patients to implement and sustain medical treatment and increase their ability to improve personal health outcomes. The multi-disciplinary team is responsible for providing comprehensive HIV care and treatment in accordance with Standards of Care outlined in the *NYSDOH AIDS Institute's HIV/AIDS Clinical and Rapid ART Initiation Guidelines*. Rapid ART initiation is efficacious, safe, and highly acceptable with few patients declining the offer of immediate ART.

The RAP will 1) facilitate rapid access to HIV treatment including immediate initiation of antiretroviral treatment after HIV diagnosis, in accordance with Standards of Care outlined in the HIV Clinical Guidelines; 2) identify and engage individuals living with HIV who are not virally suppressed in HIV care and treatment; and 3) enhance the HIV continuum of care through partnership with community providers to identify people living with HIV (PLWH) who are out-of-care, or not regularly retained in care to improve overall health outcomes of PLWH and the community.

II. PATIENT ELIGIBILITY

To be eligible for services, verification includes:

- HIV positive status
- NYS residency
- Income status
- Insurance status

In addition, patients must meet the following criteria:

- newly diagnosed with HIV
- not virally suppressed (determined by most recent viral load test within 6 months prior to enrollment)
- not enrolled in another case management program at the agency

Documentation Requirements

Programs must maintain records for all patients enrolled in the program and make them available for review by NYSDOH AI staff.

Patient records must contain the following:

- AIDS Institute – HRI Contracts Client Eligibility and Recertification Requirements form (see Appendix 2)
- Proof that patient meets eligibility for services
- Program enrollment date
- Proof of NYS Residency

- Proof of Income
- Proof of Insurance Status
- Proof of HIV status
- Documentation of the patient's most recent viral load
- Current HIV release of information forms, as applicable

III. SERVICE ACTIVITIES AND STANDARDS

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

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 3 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

All staff members providing medical case management, health education, and peer navigation are required to collaborate as a team with clearly delineated roles and responsibilities. They are expected to work together in a concerted effort to assist each patient in improving his/her medical outcomes, achieve viral suppression, and self-management. This involves ensuring that the patient has access to all services and resources in the community that will support these overall program goals. The team is expected to collaborate with other regional service providers in an effort to keep these goals at the forefront of all activities. The team will be responsible for monitoring all services until the patient demonstrates the ability to successfully manage his/her own health care arrangements (i.e., making and keeping appointments, adhering to treatment regimens, viral suppression, etc.).

In addition to providing the medically oriented services above, Medical Case Management 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).

The activities and processes listed below, and stipulated timeframes are required of all programs:

1. INTAKE

Definition: Intake is the initial meeting(s) with the patient during which the RAP Specialist provides an overview of the program services, gathers information to address the patient's immediate needs and

barriers to care, and encourages their engagement in the program. The RAP Specialist will assure the patient that privacy and confidentiality is maintained.

Process: Initial documentation must be presented as a distinct component of the patient's chart and at a minimum include:

- Contact and identifying information including preferred method of contact (name, birth date, address, phone, email address, social media, etc.);
- Language(s) spoken, including preferred language;
- Demographics (race, ethnicity, age, and sex at birth);
- Sexual orientation, gender identity, and gender pronouns;
- Living situation: Identify head of household; if dependent children are living with the patient; the housing status (e.g., rent, own); if housing is adequate;
- Household data: Household size and annual household income;
- Health insurance status;
- Citizenship;
- Emergency contact including phone and email address, alternative contacts;
- Confidentiality concerns;
- Former HIV medical providers, including reasons for terminating care;
- Current/former medications;
- Determine that form DOH 4189, Medical Provider HIV/AIDS, and Partner Contact was completed and submitted as specified on the form.
- Information regarding partners and engagement of Partner Services.
- Other current health care and social service providers, including community case management and care coordination providers (Health Homes or grant funded); and
- Transportation options.

Issues that impact patient's ability to be retained in care are identified. The patient's history regarding their continuity of medical care is assessed, and strategies for keeping scheduled medical and behavioral health appointments are identified. Immediate needs identified during the intake are addressed promptly.

Frequency: Intake is conducted once, however, the process may require more than one encounter with the patient to obtain all documentation. The first date of the intake process should be entered in AIRS. The intake must be completed no later than 14 days after enrollment has occurred.

2. ASSESSMENT

Definition: The assessment is a systematic gathering and evaluation of the strengths, resources, medical and psychosocial needs of patients. Unmet medical and psychosocial needs are identified in addition to barriers to retention and adherence to care. The assessment serves as a functional, responsive tool that drives the development of an individualized, focused service plan. It provides a mechanism for monitoring patient progress and tracking outcomes.

Process: Utilizing a strengths-based approach, the RAP Specialist and patient will use a tool to assess patient medical, behavioral and psychosocial functioning factors. HIV-related stigma should be assessed and appropriately addressed. Strategies to address social determinants of health must also be developed.

The RAP Specialist must utilize information obtained from other sources such as medical records, multi-disciplinary team members, or external care coordinators (with appropriate releases) to inform the assessment process.

The assessment can occur in conjunction with intake and can be addressed in one document. The

assessment may also be conducted over several meetings including phone calls with at least one face-to-face contact.

At a minimum, the assessment tool must document:

- Date of most recent CD4 test result with count;
- Date of most recent viral load test result with count;
- Name and address of current primary care provider;
- HIV primary care visit history;
- STI history and risk factors;
- Current medication regimen;
- Ability to adhere to medication regimen;
- Language barriers;
- Health literacy barriers;
- Patient's cognitive competence;
- Social determinants of health barriers to adherence and retention needs related to:
    - Housing;
    - Food security and access
    - Income and employment;
    - Insurance; and
    - Access to medications.
- Behavioral and psychosocial needs and supports inclusive of:
    - Mental health;
    - Alcohol and substance use treatment;
    - Family and social supports;
    - HIV disclosure assistance;
    - Intimate partner and domestic violence
    - Crisis intervention plan; and
    - Partner services.
- Unmet medical needs and gaps in care coordination; and
- Service providers, service provision, and access.

The assessment will identify:

- Adherence facilitators and potential barriers to adherence;
- The need for medication reminders or organizers;
- Challenges with keeping medical appointments (review of any past difficulties with keeping appointments);
- Social determinants of health that may impact treatment adherence, and retention in care (socio-economic & environment, living and working conditions, community networks);
- Self-management skills;
- Issues managing other chronic diseases;
- Immediate concerns or referrals needed to improve treatment adherence or retention in care; and
- Prevention and/or risk reduction needs.

The assessment process should be described in the agency's RAP Policies and Procedures Manual and includes the following requirements:

- The completed assessment must be signed and dated by the RAP Specialist;
- Supervisory review and sign-off of the assessment is required; and
- Protocols for the timeline of supervisory review and sign-off are documented.

Frequency: The assessment is conducted once but may require several patient encounters to ensure completion. The assessment must begin upon intake and be completed within 30 days. The last date

of the assessment process should be entered in AIRS.

3. MULTI-DISCIPLINARY CASE CONFERENCE

Definition: A case conference is a multidisciplinary meeting involving team members responsible for the treatment and care of the patient. It is structured to 1) exchange information, 2) review patient progress, and 3) ensure collaborative development of a coordinated patient-centered care plan to improve patient engagement, retention and adherence. Staff huddles and conversations by phone/email/video/conference calls are considered case conferences.

Case conference team members should include the RAP Specialist, at least one medical provider, and others responsible for the treatment and care of the patient. It may include, but is not limited to, the following internal or external providers: primary care or HIV physicians, nurse practitioners and physician assistants, mental health counselors, patient care coordinators, nurses, social workers, case managers, pharmacist, treatment adherence specialist, health educators, peers, substance use treatment counselors, etc.

Case conferencing promotes the integration of patient services, reduces service duplication, and improves health outcomes by:

- Reviewing the patient's progress in achieving current goals;
- Identifying or clarifying current issues affecting the patient's medical status, psychosocial needs and health outcomes;
- Promoting consensus on strategies developed to address issues and/or barriers identified;
- Delineating the roles and responsibilities of the care team and patient; and
- Informing service plan development.

Process: Patients are systematically selected for review in accordance with the frequency of reassessment schedule. External providers that share patients are encouraged to participate. This may occur in person or by telephone. When this is not possible, input and recommendations are obtained from external providers prior to the case conference and shared during the case conference. Patients may be included in the case conference as appropriate. Case conferences must be documented in the patient's chart.

Frequency: Case conferences will be coordinated with the assessment and reassessment process and will assist with the continued development and update of a patient's service plan.

RAP patients will be case conferenced:

- Within 30 days of initial appointment or enrollment; and every 90 days thereafter;
- As needed based on significant medical and/or psychosocial events likely to impact treatment and care outcomes;
- When patients are lost to follow-up (no contact for more than 90 days); and
- Prior to case closure.

4. SERVICE PLAN

Definition: The retention and adherence service plan documents actions that reduce barriers and guides the team and patient to address treatment and care goals. The service plan is referenced at each patient encounter. The service plan reflects all care team activities such as progress notes, assessments, reassessments, case conferences, and applicable patient documentation.

Process: Service plans are patient centered, developed collaboratively with the patient, based on medical needs and social determinants of health identified during assessment, reassessment, case

conferences, and other encounters with the patient. The RAP Specialist will ensure that every enrolled patient's medical history, including laboratory information, treatment adherence needs, and progress notes from other care team members, is reviewed during service plan development. Service plans are developed or updated in conjunction with all assessments, reassessments, case conferences, and as significant life events occur which impact the patient's ability to achieve goals. The RAP Specialist documents activities or interventions to meet the goals of the service plan as designed with the patient and records next steps and outcomes in the patient's chart. Updates occur when there is a change made to the plan after discussing health status, addressing and documenting achievements or barriers toward meeting goals, documenting planned activities or interventions to meet goals, and recording next steps and outcomes.

The service plan must document the following:

- Needs, goals (both long term and short term), timeframes, and responsible parties for achieving stated goals; Goals should be specific, measurable, achievable, relevant and time-bound (S.M.A.R.T).
- Outcomes;
- Signature and date of the RAP Specialist upon completion of the service plan;
- Signature of the patient as an attestation of agreement. (A copy is provided to the patient.); and
- Supervisory review and approval. (Supervisory review and approval must be within two weeks of completion of the service plan.)

Frequency: At a minimum, service plans must be reviewed and updated every 90 days, in conjunction with the reassessment and case conference.

5. REASSESSMENT

Definition: The reassessment process re-evaluates a patient's current medical and psychosocial needs through the gathering of information. The reassessment provides a mechanism for ongoing monitoring of patient's progress and tracking outcomes. This includes acknowledgement of successes, addresses previously identified barriers to care and prioritizes next steps for addressing new barriers, if any. A reassessment informs the service planning process.

Process: Utilizing a strengths-based approach, the RAP Specialist will facilitate discussion with the patient to elicit information.

At a minimum, the reassessment should update all components of the assessment as well as:

- Any unmet medical needs and gaps in care coordination. This includes an updated assessment of services:
    - Barriers to access; and
    - Inconsistent or episodic engagement in care.
- Each reassessment encounter is to be signed and dated by the RAP Specialist;
- Supervisory review and sign-off of the reassessment is required; and
- Protocols for the timeline of supervisory review and sign-off are documented.

Frequency: The reassessment may be conducted over multiple patient encounters and be completed, at a minimum, every 90 days. The last date of the reassessment process should be entered in AIRS.

6. PEER SERVICES

Peers are a valuable community resource lending credibility and cultural competence to a program. As frequent contact is a key element of this initiative, peers enhance patient support and can assist with case management efforts to engage patients (e.g., conduct outreach and provide appointment

reminders), accompany patients on appointments, and assist with health education services by sharing personal insights and experiences as a patient of similar services.

Peers must be appropriately trained and supervised to ensure that they are culturally competent and understand the goals and objectives that are being worked on in each case.

The services peers may provide include, but are not limited to:

- Orientation to new patients on RAP, clinic services, and clinic staff;
- Navigation for patients to medical visits or other health and human service appointments;
- Support, education, and adherence assistance through individual or group activities;
- Reminder calls and follow-up for missed appointments;
- Home visits (which may provide a valued insight to the medical teams' patient management strategies); and
- Assistance with engaging patients lost to care.

Documentation Requirements

Programs must maintain records for all patients enrolled in the program and make them available for review by NYSDOH AI staff.

Each peer encounter with or on behalf of a patient must be documented in a progress note and kept in chronological order in the patient chart. Progress notes must focus on specific service plan goals, the problem or issue presented, the intervention that addressed it, the agreed upon follow-up action to be taken, and the date for the next encounter. All attempts at contact with the patient must be documented, regardless of whether the attempt at contact was successful.

The scope of peer services is determined by the education, training and skill level of the peer, informed by the facility's administrative personnel policies and/or the volunteer policies, and defined within the RAP Policy and Procedures Manual. The RAP Policy and Procedure Manual must include:

- A process for recruiting and selecting peers;
- Title and job description;
- Timeframes for an initial and annual peer training program inclusive of HIV confidentiality, HIPAA rules and regulations, professional conduct, outreach skills, safety protocols, active listening and boundaries for peer/patient relationships;
- Peer supervision;
- Provision of support for the peers;
- Compensation; and
- Performance evaluation.

Compensation and title of peers are determined by the agency policy. Some agencies may decide to change the title of the staff that provide peer services to a title that is in alignment with the assigned responsibilities and to avoid possible stigma (i.e. health educator, patient educator, patient advocate, patient navigator). Peers may be salaried employees of the agency or compensated for cost associated with "services" provided with a stipend. If the peer is receiving health or social service benefits, the effect a stipend or salary may have on the peer's benefits must be considered.

See http://www.hivtrainingny.org for information on the New York State Certified Peer Worker certification. Certified Peer Workers (CPW) interested in working full time should have access to a salaried, livable wage and benefits comparable to other employees.

CPWs have an important role to play in ETE and the value of their work should be compensated accordingly.

7. CRISIS INTERVENTION

Definition: Crisis intervention refers to the methods of immediate, short term help available to individuals who experience an event that produces mental, physical, emotional, and behavioral distress. Short-term interventions are provided to help patients receive assistance, resources, stabilization, and support to address a crisis.

Process: The agency has a policy for patient crisis intervention services that is included in the agency's Policies and Procedures Manual. All RAP program staff are familiarized and trained on the agency crisis intervention policy and how to be an effective first responder during a crisis.

All onsite emergencies are immediately and effectively addressed.

The RAP Specialist discusses with the patient what constitutes a crisis.

Frequency: A crisis intervention plan is developed in collaboration with a patient, as needed. Individual plans must include, at a minimum, information on emergency contact, internal and external resources, and guidance to secure assistance outside of agency business hours.

8. RE-ENGAGEMENT EFFORTS

Definition: Re-engagement efforts are attempts to connect with patients that do not routinely engage in care (every 90 days). These activities include attempts to contact the patient, utilizing local and state provider portals (RHIOS, Health Departments, NYS HIV/AIDS Provider Portal, etc.), partner services, coordinating with other case management, medical, mental health, substance use, managed care plans and social service providers to locate the patient, and other re-engagement activities.

Process: The RAP Specialist is responsible for coordinating re-engagement efforts. The agency's RAP Policies and Procedures Manual will identify the sequence of events and the number of attempts that need to occur for re-engagement and supervisory oversight. This will include the methods for patient contact (i.e., letters, phone calls, e- mails, texts, contact via collaterals, or home visits). Peers may be used for re- engagement activities. The following resource is available: HIV Medical Providers: Strategies and Resources for Retention in Care
https://www.health.ny.gov/diseases/aids/general/standards/docs/strategies_resources_retention_in_care.pdf

Frequency: Discussions around re-engagement are initiated from the first point of the patient's contact with the RAP Specialist and/or Peer. This will enable the implementation of a proactive plan in response to a future need should there be interruption in the patient's care.

9. CASE CLOSURE

Definition: Case closure is the activity that disenrolls a patient from the program who is able to self-manage their medical needs or is discontinuing RAP services for other reasons.

Self-management is demonstrated by adherence to medical appointments and treatment regimen **and** viral load suppression as follows: patients maintain a suppressed viral load (two consecutive suppressed viral loads; at least 90 days apart).

Other reasons for case closure may include:

- Completed therapy/service
- Program-to-program transfer (to an internal program)
- Transfer to another provider (to an external program)

- Unknown/lost to follow-up
- Voluntary withdrawal
- Patient relocated/moved out of area
- Needs could not be met by program
- Non-compliant with program/agency requirements
- Incarceration
- Patient is too ill to continue
- Death
- Agency-wide closure
- Program terminated

Process: Upon termination of RAP services, a patient's case is closed, and the medical record contains a closure summary documenting the case disposition. Depending on the reason for closure, the summary must include documentation such as reengagement efforts, transfer of medical records, date of death, etc.

The agency's RAP Policies and Procedures Manual outlines the criteria and protocol for case closures. All required activities, individuals responsible, and the number of attempts for required activities must be documented in the agency's RAP Policies and Procedures Manual (e.g. phone call, letter, home visit, text messages, etc.).

When a patient's RAP case is closed, the corresponding AIRS enrollment must be ended.

Frequency: Case closure should occur when a patient maintains a suppressed viral load consistently (at least two consecutive suppressed viral loads, 90 days apart).

10. PATIENT REFERRALS

Definition: Connecting a patient with services needed to maintain continuum of care but not offered within the existing health network.

Process: Behavioral Health referrals to alcohol/substance use services, harm reduction/syringe exchange and mental health/psychology, and clinical subspecialties and community supportive services are documented and entered in AIRS. Status of referrals should be documented routinely and upon completion. Status options include attended appointment, no show, or pending.

Frequency: A referral status should be updated within 30 days of the date of referral.

IV. ADMINISTRATION

Administration refers to the management and execution functions of the agency that support the effective implementation and ongoing provision of program services.

1. Establish and maintain an administrative structure to ensure that the program is properly organized, equipped and staffed, consistent with the scope of services and patient needs.
    a. An administrator is responsible for the oversight of the program to ensure goals and objectives are met and adherence to AIDS Institute program standards.
    b. A current organizational chart delineates the program within the overall agency structure.
    c. Lines of responsibility and accountability for administrative, program, clinical and fiscal aspects of the program are clear.
    d. Staffing (including qualifications and number of staff) is consistent with the scope of grant services and supports the functions of the program.

e. Procedures are in place to inform the AIDS Institute of staffing changes or other issues affecting program implementation.

2. Agency administration supports the program through resources, leadership and ongoing participation.
   a. Program staff have access to policy making, administrative, fiscal, QI and MIS staff support.
   b. Space, equipment and other resources are adequate to sustain program operations and patient services.
   c. The governing body of the agency (Board of Directors, County Health Commissioner, or hospital administration) receives timely and regular updates on the status of the grant-funded program.

3. The agency promotes and markets the full spectrum of HIV services.
   a. Methods of program promotion include:
      i. Written materials, brochures
      ii. Establishment of linkage agreements and/or partnerships.
      iii. Meetings with community agencies and leaders
      iv. Staff participate in regional committees/community planning bodies.

4. The agency maintains a policy and procedure manual, including a program specific section.
   a. A process is in place to establish and implement program policies and procedures.
   b. Policies and procedures are developed utilizing staff input.
   c. Policies and procedures identify date developed, date(s) updated/revised and administrative signature indicating approval.
   d. Policies and procedures are reviewed annually, or more often if necessary.
   e. The policy and procedure manual is available as a resource for staff.

5. The agency has a process in place to ensure compliance with contract fiscal requirements.
   a. Program vouchers and budget modifications are submitted on time to the AIDS Institute and maximize the contract award.
   b. Routine meetings (minimally quarterly) are held between appropriate administrative, program and finance staff, allowing for the review and discussion of contract/program budgets and current expenditures, ensuring the most effective and efficient use of funding.

V. PERSONNEL

Personnel management consists of the systems needed to ensure effective recruitment, job training, evaluation, retention and ongoing support of employees. Programs are expected to hire staff that meet minimum qualifications for required positions and ensure that all staff, including peer positions, receive appropriate orientation to the program.

1. Personnel files are maintained for all HIV program staff (including peers). The content of each file includes:
   a. Position description, including responsibilities and qualifications.
   b. Resume, which reflects experience consistent with position title and description.
   c. Documentation of the initial comprehensive HIV confidentiality training, including a signed confidentiality attestation.
   d. Documentation of annual HIV confidentiality training.
   e. Annual Performance evaluations signed by supervisor and employee.
   f. Evidence of training and professional development skill building.
   g. Termination or resignation letter, as applicable.
   h. Copies of current licenses (as appropriate to position requirements).

2. A system is in place to assess staff performance and development needs and to provide ongoing training.
    a. Orientation to job expectations, agency services and specific HIV program(s) is provided to all new personnel.
    b. Staff receive ongoing training appropriate to their job responsibilities.
    c. A staff-training log is maintained which identifies attendance at trainings/in-services, including staff names, types of training and dates.
    d. HIV confidentiality training, specific to NYS PHL Article 27F, is a required element of program orientation and must occur prior to patient contact. An attestation must be signed by staff.
    e. Annual HIV confidentiality updates, specific to NYS PHL Article 27F, are required and must be maintained in the training log or personnel file.
    f. Certificates of training and/or proof of attendance are maintained.

3. Systems are in place to reduce staff turnover, minimize staff vacancies and expedite recruitment.
    a. Strategies are in place to enhance job satisfaction and employee retention.
    b. Guidelines and mechanisms are in place for efficient, prompt recruitment upon identification of a vacant position.

***It is recommended that all programs designate a Program Director or Coordinator position familiar with the provision of HIV services who will be responsible for the oversight, coordination, and outcomes of the program.*

VI. CULTURAL COMPETENCE AND HEALTH EQUITY

Culturally competent service delivery is an approach that is respectful of and responsive to an individual's value and belief systems, cultural background and heritage, and language and linguistic ability. Cultural competence also takes into consideration demographic factors such as age and gender as well as the needs of gay, lesbian, bisexual and transgender populations, individuals with disabilities, aging and racial and ethnic minority populations.

Health Equity is the fair and just opportunity for everyone to achieve optimal holistic health and well-being regardless of social position or other social or structural determinants of health. Achieving the Ending the Epidemic goals begins with building capacity to identify and address specific disparities in HIV prevention and healthcare and promote equal access and care for all.

1. The agency demonstrates a commitment to developing and implementing programs that are reflective of and responsive to the diversity of the communities it serves.
    a. Individuals representing the diversity of the patient population are involved in program design, implementation and evaluation.
    b. Services are provided in a manner compatible with consumers' cultural (health) beliefs and preferred language.
    c. Organizations must make available easily understood consumer materials. In addition, programs must post signage in the languages of commonly encountered consumers.
    d. Programs offer and provide language assistance services to patients with limited English proficiency, including bilingual staff and interpreter services. This must be offered in a timely manner at all points of contact. Family and friends should not be used to provide interpretation services (unless requested by the patient).

2. The agency is committed to ensuring that staff are reflective of the populations being served.

a. The agency implements strategies to hire, retain and promote a diverse workforce. Promotional and leadership opportunities are provided to staff representative of the populations being served.

3. Cross cultural training is required for all staff.
    a. Staff at all levels and across disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
    b. Training on effective communication is provided for staff who interact with patients.
    c. Training on anti-racism and reducing implicit bias is available for all staff.

VII. HEALTH LITERACY UNIVERSAL PRECAUTIONS

The practice of Health Literacy Universal Precautions**(HLUP) assumes that everyone may have difficulty understanding information relevant to maintaining or improving their health and creates a health literate environment where all patients can thrive. When a patient is sick, frightened or otherwise impaired, they may experience difficulty in processing or using health information. A universal precautions approach to health literacy improves health outcomes, reduces disparities and reduces costs through 1) simplifying communication and confirming comprehension with all patients, 2) reviewing and modifying the office environment and health care system for easier patient navigation, 3) supporting patients' efforts to improve their health.

1. A Health Literacy Universal Precautions approach is integrated into all aspects of care to ensure patients' understanding of information provided at all points of contact.
    a. Clinicians and case managers evaluate, and document patients' written and oral communication needs.
    b. Staff assist patients to access and understand health information to make informed health decisions.
    c. Health literacy verification is documented semi-annually at a minimum.

2. The program integrates health literacy universal precautions into their funded program policies, staff training requirements, care models, and quality improvement activities.
    a. A policy and procedure s maintained that identifies how HLUP is integrated into the program, who is responsible and how it is evaluated and documented.
    b. Training on health literacy universal precautions is provided for all staff who interact with patients.
    c. Based on a HLUP staff and clinic environment self-assessment, a QI plan is developed with clearly defined and measurable activities. See the Agency for Healthcare Research and Quality (AHRQ) HLUP Toolkit Second Edition found at: https://www.ahrq.gov/sites/default/files/publications/files/healthlittoolkit2_4.pdf
    d. Program models support patients' ability to navigate complex medical systems and to self-manage their care.

***Best practice recommendations for health literacy universal precautions include the expansion of these guiding principles agency wide. See AIDS Institute website: http://www.health.ny.gov/diseases/aids/providers/health_literacy*

VIII. CONSUMER INVOLVEMENT

Consumer involvement is a guiding principle of the New York State Department of Health, AIDS Institute. The inclusion of patients as collaborative partners in the processes of program development, strategic planning and evaluation are essential to ensuring HIV care and supportive services are delivered in a manner that is sensitive to and addresses the needs of HIV-infected individuals and

individuals at high risk of acquiring HIV, as well as supporting their retention in care. Mechanisms for HIV-infected and affected individuals/families to participate includes community advisory group, community forums, focus groups, designated consumer projects and surveys. A consumer advisory group, or similar committee, can serve as a liaison among consumers, the community and the HIV program.

1. Individuals living with HIV and affected family members have input into program design and services.
    a. The HIV program has identified strategies for gathering consumer input.
    b. Consumer input is utilized for continuous quality improvement activities and strategic planning.

2. The program has established a consumer advisory group or other opportunities for consumers to provide feedback on program development and service planning and delivery.
    a. A written plan on how consumer involvement occurs is included in the HIV program's annual Quality Improvement Plan.
    b. Consumer meetings are held regularly. Agenda and meeting minutes are documented.
    c. Consumer groups are representative of the diversity of the patient population.
    d. Opportunities are provided to consumers to work on specific quality projects, e.g., consumer materials, satisfaction surveys, new patient orientation packets, etc.
    e. Consumers are made aware of how they can make recommendations for improvement.
    f. Consumers are informed of and encouraged to participate actively in HIV planning groups, HIV/AIDS conferences, National Quality Centers Training of Consumers on Quality, and other related meetings outside the agency.

3. A consumer satisfaction survey is conducted annually, or more often, as determined by the needs of the program.
    a. The survey includes questions on key program services, as well as staffing, facility and hours of operation.
    b. Results of surveys are analyzed, and feedback is provided to consumers.
    c. Data is summarized and utilized for program development.

4. Funding and structures support consumer activities and feedback.
    a. Appropriate resources, such as training, transportation, space, and mailing materials / postage are provided to enable consumer participation.

IX. DATA REPORTING

All data required for reporting is entered into the AIDS Institute Reporting System (AIRS).

1. To accurately report contract deliverables and other relevant data through the AIDS Institute Reporting System (AIRS) and other data systems, adequate staff resources, policies, procedures, and systems exist which include:
    a. Security and confidentiality
    b. System administration
    c. Staff training
    d. Complete and timely data collection and input
    e. Report and extract generation and timely submission
    f. Quality Control
    g. Technical support

2. Data that demonstrates retention in care and monitors patients' health status provides a measure

of effectiveness of interventions in meeting the goals of the funded initiative. For patients receiving medical case management services, a system must be in place to routinely collect and report, through AIRS, the following:

a. Patient demographics and services provided data
b. Annual and semi-annual core medical indicators
c. Status updates and histories
d. Referrals

3. To ensure complete and accurate reporting of contract deliverables, the Program Director must routinely review AIRS data prior to extract submissions.
    a. Monthly extracts (both the AIDS Institute extract as well as the HIV/AIDS Epidemiology extract) are due by the 30th of the following month (generated in AIRS) and must be submitted via the Health Commerce System (HCS).
    b. The Program Director must routinely review AIRS data prior to extract submissions.
    c. Resources such as AIRS reports, External Reporting Application (ERA) reports, Electronic Medical Records, patient charts, data collection forms and billing records should be used to collect, review, and compare data.

4. Program narratives are submitted by the 10th of the following month. Monthly reports should highlight progress towards meeting program goals

***More AIRS specific related information can be found in each program's AIRS manual.*

X. QUALITY IMPROVEMENT

Quality management embraces a quality improvement philosophy to improve the health and well-being of people and communities affected by HIV/AIDS. Quality improvement involves a formal process of assessing performance, identifying areas for improvement to promote the provision of quality HIV service and implementing change. The agency's HIV quality improvement program must comply with New York State HIV Quality of Care Program Standards.

1. HIV service programs have an established quality management structure.
    a. The quality management program includes an organizational commitment that supports ongoing quality improvement activities.
    b. The quality management program has a written plan that is evaluated and updated annually and submitted to the AIDS Institute. The plan is shared with staff and implemented by an HIV quality committee.
    c. The HIV quality committee is integrated within the facility's full quality management program.
    d. An HIV program staff person oversees the HIV quality program.
    e. The quality committee includes all disciplines, with clear description of activities.
    f. The HIV quality committee is accountable for specific quality improvement activities and the communication of findings with staff and consumers.
    g. The HIV quality improvement program integrates principles of patient self-management and decision support.

2. Performance indicators guide the development and implementation of quality improvement activities.
    a. Indicators address clinical and non-clinical services and are clearly defined and prioritized.
    b. Indicators are chosen based on internal program goals and identified concerns, as well as funder and community expectations.
    c. Performance data results, staff and consumer feedback will be used to evaluate indicators.

d. Processes are linked to clinical outcomes (e.g., case conference, patient education, referral follow-up).
e. Low performance results are reviewed during quality committee meetings and used to direct improvement activities.
f. Teams implement short term quality projects on areas requiring improvement (e.g., "plan, do, study, act"- PDSA cycles).

3. Staff are actively involved in the quality management program and quality improvement activities.
    a. All program staff are represented in quality improvement activities. Clear lines of accountability are established for CQI activities, including the implementation of recommended changes.
    b. Expectations of staff involvement in quality improvement activities are outlined in job descriptions.
    c. At a minimum, annual quality improvement trainings addressing relevant quality improvement topics are provided to staff.
    d. Staff will participate in and provide program area expertise at regional meetings including, but not limited to, ETE, NY Links, and community meetings.

4. Contractor will participate in NYSDOH Quality of Care Program activities, including but not limited to the HIV Treatment Cascades.

5. Consumers participate in quality management projects.
    a. Program activities are informed by consumer input.
    b. Consumer participation in quality activities may include membership in the quality committee, participation on quality improvement teams, attending regional meetings (ETE, community meetings, etc.), reviewing performance data and linking the consumer advisory groups to the quality management committee.
    c. The quality program assesses consumer needs and satisfaction at least annually; results are compiled and used to enhance program services.

6. Quality outcomes are routinely communicated to program staff, administration and consumers.
    a. Successes and areas identified as needing improvement through the QI process are communicated to senior management whose subsequent feedback is included in the process.

XI. POLICIES AND PROCEDURES

The organization has established and implemented policies and procedures for all program components and related standards. Policies and procedures are reviewed no less than annually and updated as needed. Dates of revision and administrative approval (sign-off) must be included in the document.

1. Program Eligibility/Enrollment
    a. Documentation identifying eligibility criteria for this program.
    b. Documentation identifying the enrollment and intake process for new patients.

2. Patient Appointment Follow-up
    a. Missed appointment procedures (i.e., letter, phone call, home visit).
    b. Strategies to be taken by retention and adherence specialists to reach patients who miss appointments or are lost to follow-up to reengage in medical care.

3. Patient Referrals and Follow-up

a. Establishing and maintaining linkage agreements and referral directory.
b. Referrals for clinical, community-based case management and supportive services.
c. Follow-up on referrals (who, how documented, including data entry in AIRS, etc.), to assess status (pending, complete).

4. HIV Confidentiality
    a. Security measures for patient records and other confidential information.
    b. Identification of those within the agency, who "need to know" confidential HIV information. A list is maintained and updated routinely.
    c. Initial comprehensive and annual HIV confidentiality training for all program staff.
    d. Use of DOH HIV-related forms:
        i. DOH 2556, (1/11) HIV-Specific Model Consent Form
        ii. DOH 2557 (2/11); DOH 5032 (4/11) Authorization for Release of Health Information

5. Retention and Adherence
    a. Agency guidelines for conducting intake, (re)assessment, service planning and case closure.
    b. Policies and timeframes for supervisory review of each retention and adherence services process.
    c. Procedures for coordination with community-based case managers.

6. Multidisciplinary Case Conferencing
    a. Description of the multidisciplinary case conference, including frequency (minimally every six months), team members to be involved, and documentation requirements.

7. Participation Support Costs (needed to facilitate care)
    a. Process for determining patient eligibility for participation support.
    b. Specify the participation support that will be provided and the expected outcome(s).
    c. Process to monitor and track participant support (e.g., record keeping system for metro cards).

8. Peer Services
    a. Scope of activities, training, and peer compensation for programs using specific "peer delivered services" such as health educators, navigators, and/or outreach workers.
    b. Process for evaluating the effectiveness of peer delivered services.

9. Partner Services
    a. Process for partner counseling and referral services, including utilization of form DOH 4189, Medical Provider HIV/AIDS and Partner/Contact form.
    b. Process for domestic violence screening, patient referrals and follow-up.
    c. Process for completing required STD reporting form.

10. Crisis Intervention
    a. Description of available crisis resources for primary care and mental health services.
    b. Process, and information provided to patients, identifying after hours resources.

11. Case Closure
    a. Case closure determination process and documentation requirements, including AIRS.

12. Equipment
    a. Process for labeling and tracking equipment purchased with AIDS Institute funds.

13. Materials Review – AI Materials Review Policy and Procedure
    a. Guidance for review of materials developed and/or purchased with AIDS Institute funds.

14. AIDS Institute Reporting System (AIRS)
    a. Process for establishing and maintaining data systems to ensure complete, accurate and timely data collection, entry and reporting.
    b. Description of the process to ensure quality review of data prior to submission of AIRS data to the AIDS Institute.
    c. Description of process and time frames for AIRS data backup.
    d. Process for ensuring timely execution of AIRS updates.

15. Social Media and Technology
    a. Description of agency "acceptable use" policies and procedures pertaining to the various types of media and technologies utilized by the program to promote information exchange and communication with patients.
    b. Description of process to ensure compliance with HIV confidentiality standards.

XII. APPENDICES

APPENDIX 1

Authorization for Release of Health Information and Confidential HIV Related Information Form

The AIDS Institute makes available the "Authorization for Release of Medical Information and Confidential HIV Related Information" (DOH-2557) form and the "Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV / AIDS-related Information" (DOH-5032).

"Authorization for Release of Medical Information and Confidential HIV Related Information" (DOH-2557, 2/11)

The form was streamlined and may be used for disclosures to single parties as well as multiple parties. It may be used to allow multiple parties to exchange information among and between themselves or to disclose information to each listed party separately.

"Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information" (DOH-5032, 4/11)
This form was created to facilitate sharing of substance use, mental health and HIV/AIDS information. The form is similar to the DOH-2557 form but fulfills a need within facilities in which different teams handle substance use, mental health and HIV/AIDS related issues. In addition, this form fulfills a need between facilities and providers that care for the same patient. Like DOH-2557, DOH-5032 is intended to encourage multiple providers to discuss a single individual's care among and between themselves to facilitate coordinated and comprehensive treatment.

When appropriate, the DOH-5032 form should be used in place of (but not in addition to) the DOH-2557 form.

Both of the above forms can be accessed and printed from the NYSDOH web site at:
http://www.health.ny.gov/diseases/aids/forms/informedconsent.htm

APPENDIX 2

AIDS INSTITUTE- HRI CONTRACTS
CLIENT ELIGIBILITY AND RECERTIFICATION REQUIREMENTS

Client Name: _____

Client ID: _____

Enrollment/Eligibility Determination Date: _____

6-mo Recertification Date: _____

6-mo Recertification Date: _____

6-mo Recertification Date: _____

6-mo Recertification Date: _____

6-mo Recertification Date: _____

At least one of the following documents verifying eligibility must be attached to this checklist and easily located in the client file (electronic or hard copy, as applicable). Client eligibility must be documented in AIRS immediately upon enrollment in the funded program and every six months thereafter.

HIV STATUS

- HIV antibody test results
- Documentation of detectable HIV viral load results
- Physician (M.D., NP., P.A.) signed /written statement
- Certified referral or notation that eligibility has been confirmed. Including name of person, organization verifying eligibility, date, and nature and location of primary documentation.

- **Client files must include primary documentation of HIV positive status.**
- **HIV Status must be documented in AIRS. Once a client is determined to be HIV positive and eligible, continued verification of HIV status will be required every twelve months or until the client is indicated as being "HIV-Positive, CDC-Defined AIDS". Once a client receives this status In AIRS, continued verification is no longer required.**
- **Providers may use the "Verify" button on the HIV Status Information screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate.**

NYS RESIDENCY

- Current lease
- Current NYS Driver's License
- Government Issued ID Card
- Current voter registration card
- Current Notice of Decision from Medicaid
- U.S. Immigration, Naturalization, or citizenship card with current address
- Utility bill (within past 90 days)
- Phone bill (within past 90 days)
- Rent receipt (within past 90 days)
- Pay stubs or bank statement with client's name and address (within past 90 days)

- **Proof of New York State residency is required. U.S. Citizenship is not required. Incarcerated Individuals receiving services in jails or prisons are exempt from this requirement.**
- **If the client has a P.O. box where he/she receives mail. Information documenting the client's physical address must be included to document New York State residency.**
- **If a client lives with someone and has none of these items in the client's name, proof of residency and a letter stating that the client lives with them is needed.**
- **Client's address information must be recorded in AIRS on the Agency Intake screen. Since this is not a history in AIRS, any changes to the client's address must be updated on the Intake screen. Also, there is no verification process in AIRS associated with the Intake screen. This means that documentation of the six month of annual recertification process must be recorded in the client's record.**

***Client self-attestation may be accepted at one of two recertifications each year.

***Recertification is required every 6 months. At one of the two required recertifications during a year, grantees may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the grantee eligibility requirements. Appropriate documentation is required for changes in status and at least once a year.

AIDS INSTITUTE – HRI CONTRACTS
CLIENT ELIGIBILITY AND RECERTIFICATION REQUIREMENTS

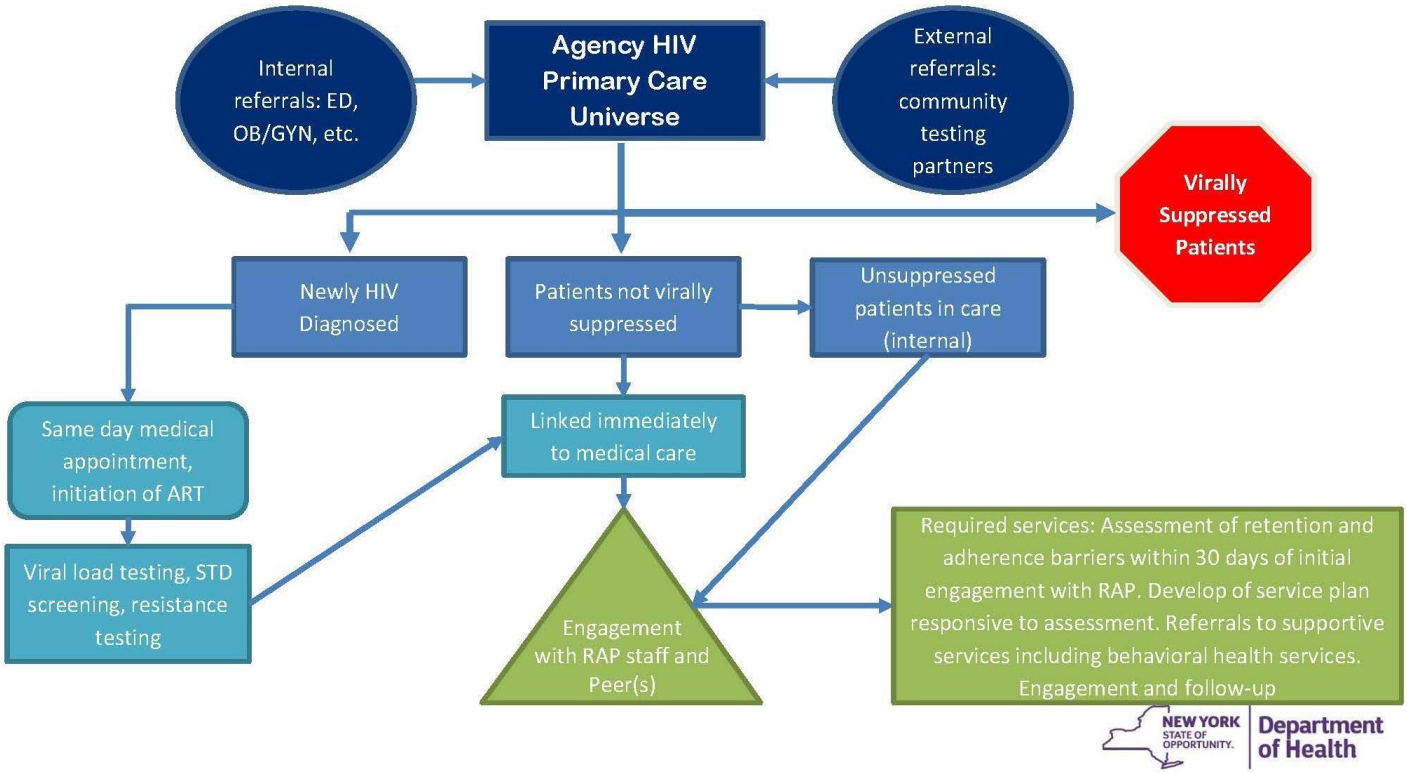
INCOME	
Employed: ➢ Paystubs covering the last 30 days showing all deductions and current year to date earnings ➢ If no paystub is available, a signed letter from employer stating gross salary, hours worked, pay period covered and the expected annual earnings	➢ **Documentation of income is required. Include all income for the client and all household members with whom the client has a legally responsible relationship (for example, spouse or child, but not uncle, cousin or roommate).** ➢ Financial eligibility is based on 500% of the federal poverty level (FPL), varies based on household size, and is updated annually. ➢ Financial eligibility is calculated on the gross income available to the household, excluding Medicare and Social Security withholding and the cost of health care coverage paid by the client. Updated Federal Poverty Guidelines may be accessed by visiting: http://aspe.hhs.gov/poverty-guidelines. ➢ Income status must be documented in the Financial Information Screen in AIRS. The Household Size and Annual Household Income fields are required. Federal poverty level cannot be calculated without these two pieces of information. The remaining fields may be used to help you record more detailed income information. Providers may use the "Verify" button on the Financial Information screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate. This means that for the in-depth recertification requirement, all client documentation was gathered and reviewed and the information in AIRS remains unchanged. If the "Verify" button was used as part of the client "self-attestation" recertification, using this button means that the client was asked and they are attesting to the fact that the information in AIRS is unchanged.
Self-employed: ➢ Both the income tax return for the previous year and a signed statement estimating current annual income	
Rental Income: ➢ Copy of the lease or most recent income tax return	
All other Income: ➢ SSD/SSI Award Letter ➢ Unemployment checks, Disability, Pension check from past 30 days	
No Income, Supported by others: ➢ Letter from person stating how they support the client	
No Income, Living off savings: ➢ Signed letter from the client and account statement showing savings	
***Client self-attestation may be accepted at one of two recertifications each year.	***Recertification is required every 6 months. At one of the two required recertifications during a year, grantees may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the grantee eligibility requirements. Appropriate documentation is required for changes in status and at least once a year.

Insurance Status	
➢ Medicaid MCO: _____ ➢ Medicaid SNP: _____ ➢ Medicare ➢ Medicare/Medicaid ➢ HIV Uninsured Care Program / ADAP ➢ Military / VA ➢ Private Insurance ➢ No Insurance	➢ A copy of insurance card should be kept in client file. ➢ Insurance Status must be recorded in AIRS and recertified every six months. Contractors may use the "Verify" button on the Insurance Status screen to indicate to the AIDS Institute that proper recertification procedures were followed and the information contained in AIRS is accurate. This means that for the in-depth recertification requirement, all client documentation was gathered and reviewed and the information in AIRS remains unchanged. If the "Verify" button was used as part of the client "self-attestation" recertification, using this button means that the client was asked and they are attesting to the fact that the information in AIRS is unchanged.
Is client enrolled in a Health Home? ☐ Yes ☐ No	If Yes, Name:
***Client self-attestation may be accepted at one of two recertifications each year.	***Recertification is required every 6 months. At one of the two required recertifications during a year, grantees may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the grantee eligibility requirements. Appropriate documentation is required for changes in status and at least once a year.

CONTRACTOR must follow client eligibility and recertification requirements developed by the New York State Department of Health, AIDS Institute. The recertification requirements are being evaluated and will be made available prior to the contract start date.

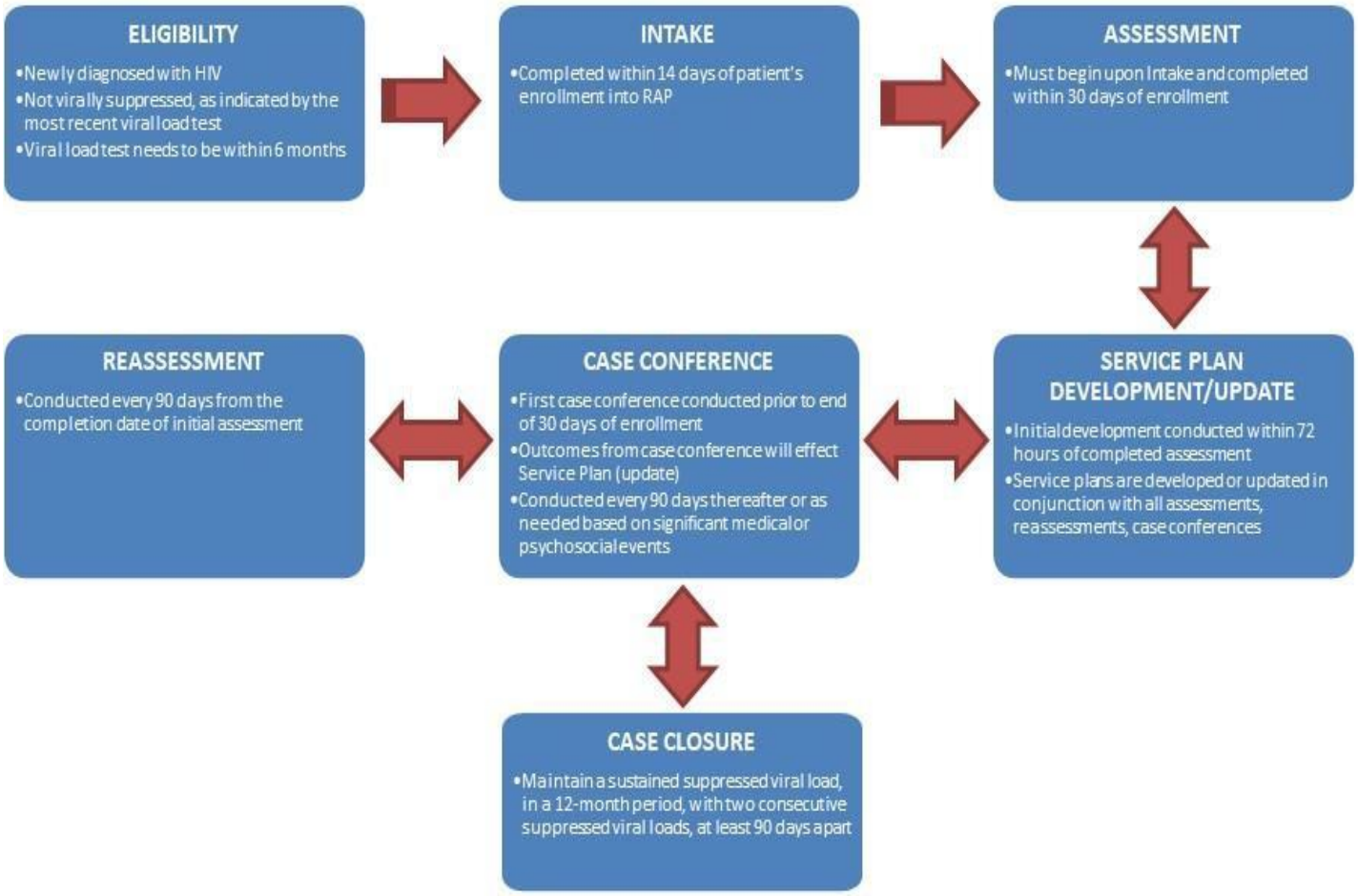
APPENDIX 3

RAP Patient Flow Chart



APPENDIX 4

RAP Services Flow Chart



APPENDIX 5

Use of Participation Support Costs and Incentives by AIDS Institute Contractors

For State – Department of Health (DOH)
and
Federal – Health Research, Inc. (HRI) Funded Contracts

Office of Administration and Contract Management
May 2018

Participation Support Costs and Incentives for Consumers

Participant support costs are the cost of providing support to enable and encourage individuals to attend programs without financial burden.

Examples of the participation support costs include, but are not limited to:

- providing a MetroCard for transportation to an HIV intervention;
- providing a food voucher for participation in an HIV program intervention; and
- providing a gift card for food, pharmacy, or transportation costs, when an individual engaged in Hep-C treatment meets a milestone, such as an RNA test confirming their cure.

Incentives are typically considered compensation to motivate individuals to be part of a program activity.

Examples of incentives include, but are not limited to:

- giving a store card (non-cash) for participation in multi-session skills building HIV program intervention.
- giving ear buds (costing less than $10) for the completion of a 4-part training on maintaining HIV negative status.

When deciding on a type of compensation/reward to be given to consumers who participate in a program activity, AIDS Institute contractors must first consider the use of participation support costs. Only when participation support costs are not appropriate, should contractors consider the use of incentives. Incentives must be reasonable in amount to be provided and the cost per incentive.

Contractors that request funding to provide participation support or incentives must obtain prior approval from their contract manager. The following information is required to obtain that approval:

- participation support or incentives that will be provided;
- dollar amount of each participation support or incentive;
- rationale for why the participation support or incentive was selected;
- service(s) supported by the contract for which participants will receive the participation support or incentive;
- eligibility criteria used;
- frequency and timeframe that the participation support or incentive will be provided; and
- description of the distribution of the participation support or incentives will be managed (e.g., record keeping, staff person responsible for dispensing, system for ensuring that the criteria are known to patients and adhered to, etc.)

Written policies and procedures addressing the use of participation support costs or incentives must be included in the contractor's Program Policies and Procedures Manual. The cost of contract manager approved participation support or incentives should be budgeted on the "Miscellaneous Other" section in HRI contracts and in the "Operating Expenses" section of New York State Grants Gateway contracts.

To supplement this protocol an AI unit can have their own protocol specific to the use of participation support costs or incentives, which further defines requirements such as the dollar amount or eligibility criteria.

Type	Allowable on a HRI contract?	Allowable in a State contract?
Participant Support		
Food Vouchers	YES	YES
Pharmacy Cards	YES	YES
Metro Cards	YES	YES
Gasoline Cards	YES	YES
Bus Passes	YES	YES
Incentives		
Gift Card – non-cash	YES	YES
Cash or Cash equivalent (e.g., VISA Card)	NO	NO
Movie Tickets	NO	NO
Theater Tickets	NO	NO
Promotional Items	NO	YES*
All other Incentives	AI staff should review the use of any other incentive with program's management and Administration prior to contractor approval to use the incentive.	

*Promotional items must be promoting a specific program or intervention, such as Ending the Epidemic, or HIV testing, or Know your Status, rather than generically promoting the organization.

Incentives are not supported by all AIDS Institute funded Initiatives. Check with your Bureau / Division to determine if this cost is supported.

Additional Information pertaining to incentives on HRI contracts is attached below.

HEALTH RESEARCH INCORPORATED

Incentive and Participant Cost Guidelines

The following information provides general guidelines for participant/incentive costs referenced under 2 CFR §§200.75 & 200.456, and is not intended to be an exhaustive resource. Appropriate policies, procedures, internal controls and documentation will be unique to each organization and its needs.

Participant/Incentive costs are incurred for the purchase of items such as MetroCards, food vouchers and gift cards which are provided to individuals who meet pre-defined contract objectives or classifications.

Participant/Incentive costs require prior approval within the contract.

Although organizations incur the expense at the time of purchase, reimbursement may not be sought until the items have been distributed and properly documented. Documentation includes, but is not limited to:

- A participant/incentive cost policy outlining an organization's purpose;
- Procedures for participation/incentive cost acquisition, distribution and internal controls for securing them;
- Proof of purchase (i.e. invoice) and payment (i.e. canceled check); and
- A distribution log.

A distribution log, at a minimum, must include:

- A serial number or distinct identifier;
- If provided to an employee of the organization for distribution, the name, date and amount of items provided to the employee;
- A description (i.e. the amount) and type (i.e. store card or money order);
- Date of distribution to the participant; and
- Either signature of employee distributing the incentive or the recipient's signature. The recipient signature is preferred.

Organizations are required to maintain distribution logs for the record retention period outlined in the HRI contract or their stated retention policy, whichever is greater.

HRI encourages Subrecipients to purchase participant items/incentives as needed. If an organization has leftover participant items/incentives at the end of the contract they may either: 1) attempt to return them to the vendor, 2) if the contract is continuing, retain them for distribution under the new contract and request reimbursement as they are provided, or 3) use them in their own operations. An organization will not be reimbursed for use of participant items/incentives utilized in their own operations.

If there are questions related to participant/incentive costs, please notify the program contact included in the contract or email Subrecipient Monitoring staff at audits@healthresearch.org

150 Broadway • Suite 560 • Menands, New York 12204 • fax 518.431.1234
www.healthresearch.org
Phone: 518-431-1204

Miscellaneous Other Expense Log - Gift Cards, Metro Cards, Food Vouchers					
Distribution Date	**Type of Card/Voucher**	**Number of cards Distributed**	**Unit Cost**	**Discount, if applicable**	**Total Expense**