

# **AIDS INSTITUTE**

## **Ryan White HIV/AIDS**

### **Engagement and Supportive Services**

#### **Initiative Guidelines**

- **Community Based Case Management & Health Education Services**
- **Medical Transportation Services**
- **Emerging Communities: Services for Gay Men & MSM**

**NEW YORK STATE DEPARTMENT OF HEALTH  
AIDS INSTITUTE  
DIVISION OF HIV AND HEPATITIS HEALTH CARE  
BUREAU OF COMMUNITY SUPPORT SERVICES  
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## I. PURPOSE, BACKGROUND AND INTENT

The Ryan White HIV/AIDS Engagement and Supportive Services Initiative Guidelines describe the New York State Department of Health AIDS Institute's (NYSDOH AI) expectations and recommendations for programs that provide services for persons living with HIV/AIDS (PLWHA) under the Engagement and Supportive Services Initiative (RFA# 14-0007).

The NYSDOH AI is committed to ending the AIDS epidemic by 2020. The Ryan White HIV/AIDS Engagement and Supportive Services Initiative (ESS) supports this commitment by increasing linkage to, engagement/reengagement and retention in care and treatment as mechanisms to achieving viral suppression and self management among PLWHA. Viral suppression is essential for improving medical outcomes for PLWHA and reducing the risk of transmitting HIV to others.

The ESS initiative is comprised of three components designed to strengthen the comprehensive continuum of HIV prevention, health care, and supportive services in New York State. The three components are: 1) Community Based Case Management and Health Education Services, 2) Medical Transportation Services, and 3) Emerging Communities: Services for Gay Men and MSM.

## II. CLIENT ELIGIBILITY

To receive ESS services, the enrolled client must:

- have documented proof of being infected with HIV/AIDS;
- be a NYS resident;
- meet all income and other recertification requirements as outlined in *Appendices 1 and 2*; and
- have an intake and initial assessment for HIV related needs and services (see *Appendix 4*).

**In addition, each service must target the following:**

### COMMUNITY BASED CASE MANAGEMENT AND HEALTH EDUCATION SERVICES

Ryan White eligible PLWHA who are either unengaged or sporadically engaged in HIV care and treatment. Services must be made available to PLWHA with active, current case management needs that present barriers to linking, engaging and retaining medical care.

### MEDICAL TRANSPORTATION SERVICES

Ryan White eligible PLWHA who experience a lack of transportation services for access to, engagement and retention in health care. This includes PLWHA who are uninsured or in need of transportation services not covered by third party payers, (i.e., Medicaid). Ryan White medical transportation services may be provided to PLWHA with Medicaid transportation coverage if there is evidence that the existing third party insurance will not provide conveyance to needed medical care and treatment services due to distance or region restrictions or significant delays that negatively impact access to health care.

### EMERGING COMMUNITIES: SERVICES FOR GAY MEN AND MSM

Ryan White eligible gay men and MSM living with HIV/AIDS who are either unengaged or sporadically engaged in HIV care and treatment. Services must be made available to gay men and MSM living with HIV/AIDS who experience barriers to linking, engaging and retaining medical care.

**ALL ESS PROVIDERS MUST ENSURE THAT RYAN WHITE FUNDING IS PAYER OF LAST RESORT.**

### III. SERVICES PROVIDED

**COMMUNITY BASED CASE MANAGEMENT AND HEALTH EDUCATION SERVICES** assist PLWHA to improve overall health and establish self-management through case management, peer navigation, and health education services. These program elements are goal-driven and focus on improving medical outcomes, achieving viral suppression, and self-management skill development.

- **Case Management:** A multi-step process that ensures timely access to and coordination of medical services and all other services that support improved health outcomes and viral suppression for PLWHA not engaged or sporadically engaged in care and treatment.
  - Processes include: intake, initial assessment of needs, service plan development and implementation, quarterly reassessment, service coordination, monitoring and follow-up, case conferencing, crisis intervention and case closure.
  - Activities to implement these processes include: service linkage and referrals, advocacy, care coordination, regular contact with client and providers, systems navigation, referrals to community resources, and activities that support skills learned through health education services.
- **Health Education:** This service category consists of group and individual sessions that focus on strategies for achieving positive health outcomes (i.e., viral suppression) independently. Sessions are curricula-based with an emphasis on basic HIV-related knowledge, treatment education, health literacy (e.g., understanding blood work results and treatment regimens, self-advocacy with medical providers), building support systems, and transmission prevention.
- **Peer Navigation:** The use of peer navigators is required of Case Management and Health Education providers. Peer navigators can provide the following services: conduct outreach and engagement efforts, assist clients in self-advocacy and self-management, accompany clients on clinical and supportive service appointments, assist the Case Manager during some interventions, and assist the Health Educator during some sessions.

**MEDICAL TRANSPORTATION SERVICES** ensure that transportation is not a barrier to the receipt of HIV primary care and Ryan White fundable support services by connecting the PLWHA to HIV primary care and treatment services. This service provides conveyance for PLWHA to medical, dental, behavioral health, and other Ryan White fundable HIV-specific service appointments that support positive medical outcomes. Conveyance can be provided via the following services: direct agency or subcontracted transportation (care/van), gasoline cards, taxi/car service fare vouchers, or public transportation fares (Metrocard, token, bus fare, etc.).

**EMERGING COMMUNITIES: SERVICES FOR GAY MEN AND MSM** engage and re-engage gay men and MSM living with HIV/AIDS who are not currently engaged or sporadically engaged in treatment and care by addressing the specific needs that gay men and MSM living with HIV/AIDS present with when seeking services. Program services must focus on improving medical outcomes and viral suppression. Service interventions must be goal-driven and remain within the purview of Ryan White fundable services; and may include: case management, health education, treatment education, risk reduction education with serodiscordant couples, social media interventions, and other Ryan White fundable support services for PLWHA.

These programs are region-specific, targeting three areas identified by HRSA in Upstate New York that have a significant prevalence of AIDS cases in Western, Northeastern, and the Finger Lakes Regions:

- Albany-Schenectady- Troy, NY Metropolitan Statistical Area (Principal Cities: Albany, Schenectady, and Troy - Counties: Albany, Rensselaer, Saratoga, Schenectady, and Schoharie.)

- Buffalo-Cheektowaga-Niagara Falls, NY Metropolitan Statistical Area (Principal Cities: Buffalo, Cheektowaga, and Niagara Falls - Counties: Erie, Niagara)
- Rochester, NY Metropolitan Statistical Area (Principal City: Rochester – Counties: Livingston, Monroe, Ontario, Orleans, Wayne)

## IV. SERVICE REQUIREMENTS

All ESS providers are expected to make services available to all eligible PLWHA in their **geographic region** and not limit services to their clients only. ESS providers are expected to collaborate with other regional providers and develop a system for making all services available through referral networks. In addition, providers will identify and leverage other community resources that: 1) enhance the provision of service delivery, 2) assist clients to overcome personal or cultural barriers that prevent them from accessing care and treatment, and 3) address issues that may compromise their overall health status. All ESS providers must ensure client HIV confidentiality and complete confidential Release of HIV Information forms for all contacts made on behalf of clients.

### COMMUNITY BASED CASE MANAGEMENT AND HEALTH EDUCATION SERVICES

**Case Management Services** pro-actively address the immediate and ongoing needs presented by the PLWHA. The focus is on engaging and re-engaging PLWHA into care and treatment, with an emphasis on frequent contact as a means of retaining them in care, avoiding health-related crises, and achieving viral suppression and self-management. Activities and interventions include, but are not limited to:

- referrals to services;
- advocacy with providers and community resources;
- negotiation for services;
- skills development;
- addressing personal, cultural and systemic barriers to engagement in care; and
- general education and support.

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

ACTIVITY	PROCESS
<b>Intake</b>	Intake due within 7 days of referral.
<b>Assessment</b>	Assessment due within 7 days of enrollment.
<b>Reassessment</b>	Reassessment due within <b>90</b> days of completion of initial assessment or previous reassessment.
<b>Service Plan Development</b>	Service plans are developed with each client during every assessment/ reassessment process and are due in conjunction with completion of the assessment/reassessment.
<b>Case Conferences</b>	Case conferences are conducted, at a minimum, every <b>90</b> days as part of the quarterly reassessment process, and as needs dictate.
<b>Crisis Intervention</b>	All programs must have training and contingency plans, as well as linkages, for immediate referrals for when clients present in crisis. All programs must also have a crisis plan for times when the agency is closed (i.e., providing a crisis hotline number).
<b>Case Closure</b>	Cases should be closed when the client no longer needs or wants services, when the client is transitioned to a more appropriate program (e.g., Medicaid Health Home), or when the client is "lost to contact" for more than six months. <b>Programs must continue to maintain diligent efforts throughout this six month period to engage clients lost to care.</b>
<b>Client Contact</b>	Case Managers are expected to maintain weekly contact with the client. Weekly contact can occur via face-to-face encounters, telephone, text, email, etc. A minimum of one face to face encounter is expected per month. All attempts at contact, regardless of whether or not contact is achieved, must be documented. Case managers must also maintain regular contact with providers, with frequency determined by need. A minimum of one case conference with all key providers (medical, specialty, behavioral health and any support services) must take place every 90 days as part of the quarterly reassessment process

Case management providers must establish and document active bi-directional linkages with regional providers of services including but not limited to: primary medical care, medical case management, behavioral health (both mental health and substance abuse treatment), housing and entitlement, nutrition, transportation, legal, and peer services.

Each case management encounter with or on behalf of a client must be documented in a progress note and kept in chronological order in the client chart. Progress notes must focus on specific service plan goals, the problem or issue presented, the actual intervention that addresses it, the agreed upon follow-up action to be taken and the date and time of next encounter. Progress notes should contain the following information:

- Date and time of encounter
- Referrals to/from service providers
- Individual and group health education sessions
- Interventions conducted with or on behalf of client
- Attempts at contact with client, family and providers, whether successful or not
- Needs being addressed and the corresponding service plan goal(s)
- Peer navigator activities
- Follow-up activities to monitor referrals and verify client follow-through
- Date and time of next encounter
- Disenrollment date and status (there must be a corresponding case closure summary)

#### **Working with the Health Home/Medicaid Eligible client:**

To ensure that Ryan White funds are payer of last resort, programs must screen clients for eligibility to receive services through other programs (e.g., Medicaid, Medicare, VA, HIV Uninsured Programs/ADAP, private health insurance), reassess and document client eligibility for Ryan White services every six months.

The HIV-infected individual with Medicaid is eligible for, and should be enrolled in, a Medicaid Health Home Care Management Program. For Medicaid eligible clients, Ryan White grant funded Case Management and Health Education programs must maximize existing resources and support client entry and retention into Medicaid Health Home programs.

Reasons for providing grant-funded services to a Medicaid eligible client must be clearly documented in the client chart, and all efforts must be geared toward transitioning the Medicaid client into the most appropriate program.

#### **HEALTH EDUCATION SERVICES**

Health Education Services must be made available to any PLWHA in the region, regardless of where or whether they receive case management services. Health education follows a "course of study" format with a set number of sessions leading to completion of the curriculum. Health education services should be structured to enhance the knowledge base, health literacy, and self-efficacy of PWLHA in accessing and maintaining HIV medical services and health. All proposed curricula must be pre-approved by the AIDS Institute.

Case Managers, Health Educators, and Peer Navigators are required to collaborate as a team with clearly delineated roles and responsibilities (see **V. PROGRAM STAFFING**). They are expected to work together in a concerted effort to assist each client in improving his/her medical outcomes, achieve viral suppression, and self-management. This involves ensuring that the client 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 client successfully manages his/her own health care arrangements (i.e., making and keeping appointments, adhering to treatment regimens, etc.).

All programs providing health education services are expected to conduct the activities and processes listed below within the stipulated timeframes:

ACTIVITY	PROCESS
<b>Health Education Screening</b>	<p>Completed within 7 days of referral from either an outside agency or a Case Manager; and assess the client's understanding of the following topics:</p> <ul style="list-style-type: none"> <li>• Understanding the importance of viral suppression</li> <li>• Health literacy and HIV related knowledge</li> <li>• Understanding laboratory results</li> <li>• Effective communication with medical providers</li> <li>• Understanding consequences of poor/sporadic medication adherence</li> <li>• Developing strategies for medication adherence</li> <li>• Managing co-morbidities</li> <li>• Reducing the risk of transmitting HIV</li> <li>• Understanding transmission and prevention of HIV, STI, and Hepatitis C</li> <li>• Goal setting and problem solving strategies</li> <li>• Stress reduction techniques</li> <li>• Building support networks</li> </ul>
<b>Group and Individual Health Education</b>	<p>Interventions are both evidence and curricula-based activities designed to improve medical outcomes by reinforcing a client's ability to build necessary support systems, dismantle barriers to accessing and adhering to care, and support the achievement of viral suppression and self-management skills.</p> <p>Interventions should occur face-to-face but may take place over the phone if there are HIV confidentiality, transportation, or security concerns.</p>
<b>Health Education Plan Development</b>	<p>Health Educators must develop a health education plan that includes health education goals, specific activities, and regularly updated needs and outcomes.</p>

The Health Educator must document each individual and group session in a progress note. Individual session progress notes contain the following:

- Date and time of session
- Topics, goals and objectives of the education session
- In what manner education occurred – face to face or telephone
- Duration of the education session
- The client's level of participation, progress, accomplishments, further needs and referrals in client's record
- How the education session promoted and supported client access to care, adherence to treatment and improved medical outcomes
- Any activities assigned to the client for utilizing information shared and for practicing skills learned
- Date and time of next session

Group session progress notes contain the following:

- Date and time of session
- Topics, goals and objectives of the education session
- Number of individuals in attendance
- Duration of the session
- General content of discussion
- Any significant issues raised and how they were addressed
- Date and time of next session

**Working with the Health Home/Medicaid Eligible client:**

Health Home Care Management clients may be enrolled into Health Education Services provided that there is no duplication of effort through the Health Home.

**PEER NAVIGATORS:**

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 client support and can assist with case management efforts to engage clients who are resistant to or sporadically engaged in HIV health care, (e.g., conduct outreach and engagement efforts), accompany clients on appointments, and assist with health education services by sharing personal insights and experiences as a client 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.

Each peer encounter with or on behalf of a client must be documented in a progress note and kept in chronological order in the client 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 client, family members and providers must also be documented, regardless of whether the attempt at contact was successful.

**MEDICAL TRANSPORTATION SERVICES**

Services are for the PLWHA who experiences a lack of transportation services for access to, engagement and retention in health care. This includes PLWHA who are uninsured or in need of transportation services not covered by third party payers, (i.e., Medicaid).

Medical transportation services include conveyances provided directly or through a voucher to an eligible client to access HIV-related health care. Transportation to Ryan White fundable support services, intended to improve medical outcomes, may also be provided. Medical transportation services must be made available to all PLWHAs. The medical transportation destinations (e.g., HIV primary care, substance use treatment, mental health, Ryan White health education groups) and frequencies (e.g., round trip twice a week, one way once a month) must be tracked and documented for all clients enrolled in the program.

Ryan White medical transportation services may be provided to PLWHA with Medicaid transportation coverage if there is evidence that the existing third party insurance will not provide conveyance to needed medical care and treatment services due to distance or region restrictions or significant delays that negatively impact access to health care. ***Funded medical transportation services may not be used for personal errands, including shopping, banking, social or recreational events, travel to restaurants or family gatherings.*** Please refer to your HRI contract, Attachments B and B1 for fundable services and unallowable costs.

***Eligibility for medical transportation must be assessed every six months. Clients determined to be Medicaid eligible must be referred to a Medicaid transportation provider. Reasons for utilizing this grant funded medical transportation program to transport Medicaid-eligible clients must be justified and documented in the client record.*** Program policies and procedures related to client eligibility, confidentiality, documentation, quality assurance, service prioritization and waiting list management, and tracking systems are critical to the successful implementation of a medical transportation program. It is expected that programs offering more than one type of conveyance service will utilize the most cost-efficient means of conveyance, based on individual need and circumstance.

The Transportation Coordinator will develop linkages with case managers, primary care providers, and other regional providers of medical and supportive services (as well as other providers of transportation service) for the purposes of ensuring client access to all services, and for verification of attendance at all service appointments for which grant funded medical transportation has been provided.

Medical Transportation Services to be provided include one or more of the following:

- Directly provided agency OR subcontracted transport (by car or van)
- Provision of Metrocards, public transportation tokens or bus fare
- Provision of cab fare vouchers
- Gas cards (when determined to be the most cost-efficient means of transportation)
- Provision of train tickets

All directly provided or subcontracted transportation services under this component must maintain client confidentiality and enable clients to be transported safely with reasonable waiting and travel times. Medical transportation providers must ensure reasonable scheduling flexibility, including service hours which coincide with client appointments, enabling them to arrive in time to keep appointments. All hired or subcontracted drivers must have a valid New York State license, automobile insurance, vehicles must be appropriately inspected, properly insured and have a routine maintenance schedule. Any agency owned vehicles, used for client transportation in this program, must also be appropriately inspected, properly insured and have a routine maintenance schedule.

#### **EMERGING COMMUNITIES: SERVICES FOR GAY MEN AND MSM**

The Emerging Communities: Services for Gay Men and MSM programs focus on accessing comprehensive health care with the specific goal of viral suppression and self- management among gay men and MSM living with HIV/AIDS. It has been clinically proven that HIV-infected individuals with undetectable viral loads are far less likely to transmit HIV to their partners. To achieve viral suppression, there must be consistent medical care and adherence to treatment regimens.

All services offered must remain within the purview of Ryan White fundable services and must meet Ryan White requirements regarding client eligibility and use of grant funds as payer of last resort. In addition, all services must be tailored to address the overall health care needs of HIV-infected gay men and MSM, incorporating a network of regional providers that address medical care, mental health, substance use treatment, and other services that support improved health outcomes.

Services can include case management, health education, treatment education, risk reduction education for sero-discordant couples, social media interventions with clients and other Ryan White fundable support services. Emerging Communities programs utilizing the Case Management and Health Education Services model must adhere to the same service requirements described in these guidelines. Programs must validate client identities (i.e. bisexual, closeted, straight) and maintain staff who are culturally competent and aware of the impact that HIV stigma and homophobia has had on this population.

Any form of social media utilized by Emerging Communities programs must be client focused interventions. These media based interventions and their outcomes must be described and reported on in the monthly program reports submitted to the AIDS Institute.

## V. PROGRAM STAFFING

Programs are expected to hire staff that meet minimum qualifications for required positions. Programs are to ensure that all staff, including Peer Navigators, receive appropriate orientation to the program. HIV confidentiality training is a required element of program orientation and must occur prior to client contact. Programs must ensure that regular supervision of and ongoing training for staff is provided as well as professional development opportunities. Programs are expected to collaborate with the NYSDOH AI for ongoing training and ESS provider meetings.

### COMMUNITY BASED CASE MANAGEMENT AND HEALTH EDUCATION SERVICES

All **Case Management and Health Education Programs (and Emerging Communities program staff performing similar duties)** must adhere to the minimum staffing requirements. Funding under this initiative will **NOT** support the funding of Case Managers or Health Educators across multiple initiatives or funding streams. The Peer Navigator position is required for Case Management and Health Education Programs and can be a volunteer or a paid full time or part time position.

#### **Required minimum Case Management staffing and duties:**

One or more 1.0 Full Time Equivalent (FTE) HIV/AIDS Case Managers to:

- Engage the client not in care or sporadically in care. Employ skill techniques to actively support clients in activities that improve their health outcomes resulting in sustained viral load suppression;
- Conduct multidisciplinary case conferences and coordinate services and referrals with service and clinical providers that facilitate a client's engagement and retention in care;
- Address and remove barriers to enable client access to all necessary components of health care, including mental health and substance abuse services;
- Negotiate and advocate on behalf of clients for services that support self-sufficiency and self-management;
- Collaborate with the Health Educator to identify needed and appropriate health education services for clients; and
- Work with the Peer Navigators to engage clients into care and treatment and support services.

#### **Required minimum Case Manager qualifications:**

- B.A. or B.S. with 2 years of experience working in the field of HIV/AIDS, behavioral health, substance abuse or other chronic illnesses;
- Familiarity with regional HIV primary care, mental health, substance abuse and other services and resources;
- Possess an understanding of community level work and the importance of collaborating and coordinating with other organizations;
- Effective communication and documentation skills; and
- Cultural and linguistic competence for the target population.

#### **Required minimum Health Education staffing and duties:**

One or more 1.0 Full Time Equivalent (FTE) HIV/AIDS Health Educators to:

- Screen clients for health education needs;
- Develop and implement health education service plans;
- Develop health education curricula and activities;
- Facilitate group and individual health education sessions; and

- Collaborate with the Case Manager in assessing client need, developing service plans, and participating in case conferences.

**Required minimum Health Educator qualifications:**

- B.A. or B.S. with 2 years of experience working in the field of HIV/AIDS or other chronic illness;
- 2-3 years of experience developing and facilitating health education;
- Possess an understanding of community level work and the importance of collaborating and coordinating with other organizations;
- Effective communication and documentation skills; and
- Cultural and linguistic competence for the population served.

**Required minimum Peer Navigator staffing and duties:**

One or more Peer Navigator(s) to:

- Conduct outreach and engagement efforts to engage and retain clients in care;
- Assist clients in self-advocacy and self-management;
- Accompany clients on clinical and supportive service appointments;
- Assist Case Managers during some interventions; and
- Assist the Health Educator during educational sessions.

**Required minimum Peer Navigator qualifications:**

- Ability to speak and write clearly;
- Be reflective of the communities/populations being served (bilingual, PLWHA, African American, Latino, LGBT, former substance users, etc.); and
- Be knowledgeable about the region's services and familiar with navigating the systems of care.

**MEDICAL TRANSPORTATION SERVICES**

All **Medical Transportation** programs must adhere to the minimum staffing requirement. Funding under this initiative will **NOT** support the funding of Medical Transportation Coordinators across multiple initiatives or funding streams.

**Required minimum Medical Transportation staffing and duties:**

A 1.0 Full Time Equivalent (FTE) HIV/AIDS Medical Transportation Coordinator to:

- Conduct outreach to promote transportation services to PLWHA and to community providers serving HIV-infected individuals especially in underserved communities;
- Receive requests for transportation service from provider agencies and/or clients;
- Screen referred clients for eligibility and assess transportation needs to determine what mode of transportation best meets the client's needs;
- Arrange transportation for clients according to the program's policies and procedures;
- Track the status of transportation services to ensure proper delivery and appropriate follow-up, as needed;
- Develop a system to verify that clients attend medical or Ryan White fundable services or appointments as intended; and
- Assist with troubleshooting/following-up on complaints and incident reports; vendor billing reconciliations; monthly report preparation and identify new vendors when needed.

**Required minimum Medical Transportation Coordinator qualifications:**

- High school diploma/GED;
- 1 year experience working in the field of HIV/AIDS, behavioral health, substance abuse or other chronic illnesses;
- Good organizational and interpersonal communication skills; and
- Knowledge of local and regional transportation systems.

## VI. DATA REPORTING

All services are reported on a monthly basis using the AIDS Institute Reporting System (AIRS) The AIDS Institute requires the maintenance of unduplicated client level data (including demographics, services, and health status updates) and the reporting of such data, on a monthly basis, using AIRS.

- AIRS data extracts are submitted electronically within 30 days of the end of each month. AIRS data should be checked for completeness and accuracy prior to submission.
- For each service provided, whether individual or group, the encounter must be recorded in AIRS in the appropriate service categories.
- All client referrals and referral outcomes are tracked in AIRS.

### *COMMUNITY BASED CASE MANAGEMENT SERVICES*

(and Emerging Community program staff performing similar duties) are expected to use, document and track the following services in AIRS:

Service #	Service	Description
436	Intake	Within 7 days of referral an intake must be conducted to determine if the client is eligible for Ryan White services and to assess the client's immediate and ongoing needs. Once the client is determined to be eligible and the program is suitable to meet the needs presented, the client is enrolled in the program. The AIRS intake form will be provided by the AIDS Institute and should be completed within 7 days of referral to the program. The intake should include all required eligibility information as well as HIV/AIDS status and risk behavior.
35	Assessment	Within 7 days of enrollment an Assessment must be conducted with the client to determine pertinent needs and to establish a foundation for developing the Service Plan. Planned interventions and goals must focus on all barriers to engaging in care and attaining viral suppression and self management. The AIDS Institute will provide an Assessment form that will incorporate all required information.
702	Reassessment	Reassessments are due 90 days after completion of the Assessment and every 90 days thereafter, or 90 days after the previously completed reassessment. This will be a brief form that focuses on progress toward service plan goals, updating core indicators, status/histories and the establishment of any new needs.
772	Service Plan Development/Update	As part of the Assessment and Reassessment process, a Service Plan must be developed that incorporates goals and objectives, specific activities and responsibilities, and outcomes. A service plan must be updated when goals are met or when new needs are identified.
773	Service Plan Implementation/Monitoring/Follow-up	Any interventions that are directly related to service Plan goals and support the overall goals of viral suppression and self-management are captured in this

		service category. Case Management activities must focus on implementing the established Service Plan. Interventions with the client, on behalf of the client and with providers should be directly related to Service Plan goals.
73	<b>Case Conference</b>	The goal of the case conference is to ensure that all key providers (medical, specialty, behavioral health and any support services) involved with the client are working together to achieve the same overall goals of viral suppression and self-management. It is expected that Case Managers will facilitate a case conference with these providers once every 90 days, or more often as needed, as part of the reassessment process.
366	<b>Home Visit</b>	ESS Case Management is community based and should involve home visits as part of a reassessment process or as a means of assessing the client's functioning level and barriers and resources.
137	<b>Crisis Intervention</b>	Programs must have a plan in place for when clients present in a manner that shows a clear threat to their own safety or the safety of others. Clients must have access to emergency services at all times so the program must put into place procedures to be followed during these crises. These procedures must include ways to access emergency services (i.e., provision of a crisis hotline number) when the agency is closed for business.
72	<b>Case Closure / Discharge</b>	Examples of when a case is closed and client is discharged (disenrolled) are when the client has: <ul style="list-style-type: none"> <li>• Met all goals</li> <li>• Declined/refused services</li> <li>• Transitioned to a more appropriate program</li> <li>• Been incarcerated</li> <li>• Passed away</li> <li>• Become lost to follow-up, despite multiple attempts at engaging.</li> </ul>

**HEALTH EDUCATION SERVICES**

(and Emerging Community staff performing similar duties) are expected to use, document and track the following services in AIRS:

<b>Service #</b>	<b>Service</b>	<b>Description</b>
1318	<b>Health Education Screening</b>	As part of the Assessment process, clients enrolled in ESS Case Management and Health Education programs must be screened for Health Education needs to determine if the client should participate in Health Education group or individual sessions. Health Education Screenings should focus on assessing the client's level of knowledge when it comes to understanding HIV disease progression, treatment and management.

<b>346</b>	<b>Health Education - Individual</b>	Programs must offer Individual Health Education Sessions for those clients who have health education needs but either cannot attend group sessions, are uncomfortable or do poorly in group settings, or have specific educational needs that require additional individual sessions. These sessions should be based on an established curriculum and should cover required topics listed in Section IV. Service Requirements.
<b>345</b>	<b>Health Education - Group</b>	Programs must offer Group Health Education sessions that focus on established curriculum topics and also offer opportunities for clients to share successes and resources. Programs must develop a curriculum that covers required topics listed in Section IV. Service Requirements.
<b>1317</b>	<b>Health Education Plan Development/Update</b>	The Health Educator must develop a Health Education Service Plan when a client enrolled in Health Education services is not receiving case management services. This plan must incorporate specific educational goals and objectives, activities and responsibilities, and outcomes.

**PEER NAVIGATOR SERVICES** are expected to use, document and track the following services in AIRS:

<b>Service #</b>	<b>Service</b>	<b>Description</b>
<b>1260</b>	<b>Appointment Reminder</b>	Peer navigators can assist clients in engaging in HIV care and treatment by providing appointment reminders. These can be provided at prearranged intervals (i.e., the day before, two hours before, etc.) via phone, text or email.
<b>1319</b>	<b>Program Orientation</b>	For clients new to the agency or to HIV related services in general, or those that are reluctant to accept services, Peer Navigators should provide the client with a program orientation. This involves a description of services, a tour of the facility, an introduction to staff members, and a review of client rights and responsibilities. Peer navigators may also provide a program orientation to other internal programs or to programs in the community.
<b>1228</b>	<b>Peer Escort</b>	For clients who have difficulty keeping appointments or a lack of patience during extended clinic wait periods, or who express a significant level of anxiety around HIV and medical care in general, Peer Navigators can offer accompaniment to appointments. Peer accompaniment offers opportunities to model self-management and self-advocacy skills.

773	<b>Service Plan Implementation/Monitoring/Follow-up</b>	Under the directive of Health Educators and Case Managers, Peer Navigators can participate in activities that focus on implementing the Service Plan and achieving established goals. These activities can include contacting providers, arranging appointments, following up on referrals and general skills building.
<p><b>The following indicators/status/histories are to be reported for each Case Management, Health Education and Emerging Communities client every six months:</b></p> <ul style="list-style-type: none"> <li>• Current HIV primary care provider name and address</li> <li>• Dates of all HIV primary care visits within the previous six months</li> <li>• Date of most recent viral load test and count</li> <li>• Household data</li> <li>• Insurance status</li> </ul> <p><b>Additionally, these indicators/status/histories must be reported annually:</b></p> <ul style="list-style-type: none"> <li>• HIV/AIDS Status</li> <li>• Date of most recent CD4 test and count</li> <li>• HIV/AIDS Risk Behavior</li> <li>• Housing Status</li> </ul>		
<p><b>MEDICAL TRANSPORTATION SERVICES</b> are expected to use, document and track the following services in AIRS:</p>		
Service #	Service	Description
1307	<b>Transportation Assessment</b>	A transportation assessment must be conducted upon enrollment in the program. Client transportation needs must be assessed to determine which mode of transportation best meets those needs and is most cost efficient. Six month reassessments will be tracked as transportation assessments.
1201	<b>Transportation Coordination</b>	Transportation coordination involves brokering with outside providers (cab companies, gasoline providers, car service, public transportation systems, etc.), coordinating scheduling and routes of direct agency transport, verifying that service appointments are RW fundable, verifying service locations and hours of operation, verifying completion of conveyance, issuing and collecting client travel logs, and any other tasks involved in ensuring client conveyance to needed medical and other fundable appointments.
161	<b>Direct Agency Transport (Car/Van)</b>	Conveyance of clients to and from fundable appointments via agency owned and operated vehicles.
991	<b>Gasoline Card Provided</b>	Issuance of cards of specific value that the client can use to purchase gasoline only. The amount issued must reflect the estimated amount of fuel needed to convey the client to and from preapproved fundable appointment(s).
689	<b>Provision of Cab Fare</b>	Prearranged cab conveyance to and from fundable

		appointments that is paid for via vouchers. Cash cannot be given to clients for cab conveyance.
<b>796</b>	<b>Subcontracted Transport (Car/Van)</b>	Any transportation service (car or van) that the program subcontracts with for the purpose of conveying clients to and from fundable appointments.
<b>1142</b>	<b>Metrocard</b>	Cards for one-way or round-trip subway or bus fare value issued to clients within the New York City area for conveyance to and from preapproved fundable appointments.
<b>690</b>	<b>Provision of Token/Bus Fare</b>	One-way or round-trip fare in any public transportation system within New York State issued to clients for conveyance to and from preapproved fundable appointments.
<b>1081</b>	<b>Train Tickets Provided</b>	One-way or round-trip train fare on any system within New York State for client conveyance to and from preapproved fundable appointments.
<p><b>Medical Transportation Programs will be required to document in AIRS client status histories for all clients enrolled in this program. Additionally, programs will be required to use AIRS for documenting each client's medical transportation encounter, date of service, mode of transportation and value of the service.</b></p> <p><b>The following indicators/status/histories must be reported for each client every six months:</b></p> <ul style="list-style-type: none"> <li>• Household data</li> <li>• Insurance status</li> </ul> <p><b>Additionally, these indicators/status/histories must be reported annually:</b></p> <ul style="list-style-type: none"> <li>• HIV/AIDS Status</li> <li>• Housing Status</li> </ul>		

## VII. PROGRAM EXPECTATIONS

The following facilitate the optimal operations of all programs under the Engagement and Supportive Services (ESS) Initiative. Programs must ensure, and document, adherence to the policies, procedures and guidance areas identified below.

<b>1. AGENCY OPERATIONS</b>	
<p>ESS programs will provide programmatic and administrative support to ensure deliverables are met and will demonstrate capacity to receive funds and administer them in compliance with the intent of the funding.</p>	<p>Programs must ensure:</p> <ul style="list-style-type: none"> <li>• Efficient fiscal operations, appropriate time and effort reporting, and timely submission of budgets, budget modifications and vouchers.</li> <li>• Programmatic oversight to ensure goals and objectives are being met and adherence to AIDS Institute ESS Initiative Guidelines.</li> <li>• Adherence to Ryan White requirements.</li> <li>• Programmatic and administrative supervision of program staff.</li> <li>• Effective usage of client advisory groups.</li> <li>• Communication and collaboration with AIDS Institute staff and timely and appropriate responses to all requests.</li> <li>• Attendance at all required AIDS Institute meetings and trainings.</li> <li>• Proficiency in AIDS Institute data reporting requirements (e.g., AIRS) and that computer systems are adaptable as changes and updates occur.</li> <li>• Program policies and procedures address the following:                             <ul style="list-style-type: none"> <li>○ Client eligibility which includes screening clients for eligibility to receive services through other programs (e.g., Medicaid, ADAP);</li> <li>○ HIV confidentiality and other appropriate training of all ESS program staff;</li> <li>○ Security and confidentiality of client information;</li> <li>○ Documentation of services provided;</li> <li>○ Client rights, consent, responsibilities, grievances, noncompliance, and loss to follow-up;</li> <li>○ Coordination of services with other HIV service providers;</li> <li>○ Processes to facilitate client retention in, and adherence to HIV medical care and treatment;</li> <li>○ Quality management and data reporting; and</li> <li>○ Protocols specific to the provision of ESS services.</li> </ul> </li> </ul>
<p>ESS programs must demonstrate effective human resource practices, including hiring standards, discipline processes, staff evaluation processes, and the development and provision of job descriptions.</p>	<p>Personnel files must be kept on all funded staff and contain:</p> <ul style="list-style-type: none"> <li>• Application for employment and/or resume.</li> <li>• Job descriptions that include: position title, responsibilities, lines of supervision, education/training, work experience and other qualification for the positions.</li> <li>• Evidence that staff on contract meet job qualifications.</li> <li>• Signed confidentiality statement.</li> <li>• Evaluations signed by supervisor and employee; timeframes for evaluations must be consistent with agency policy.</li> <li>• Evidence of training and professional development skill building.</li> <li>• Salary adjustment information.</li> <li>• Attestation of receipt of Agency Policy and Procedure Manual.</li> </ul>

<b>2. PROGRAM SAFETY AND ACCESSIBILITY</b>	
ESS services should be provided in settings that ensure the well-being and safety of clients and staff. Facilities should be easily accessible by all, clean, comfortable and free of hazards.	<ul style="list-style-type: none"> <li>• Program promotes and practices Universal Precautions.</li> <li>• Program is Americans with Disabilities Act (ADA) compliant for physical accessibility; and services are accessible to target population.</li> </ul>
<b>3. CRISIS INTERVENTION</b>	
ESS programs are required to have a crisis intervention plan in place to address the needs of clients that may present with emergencies or severe symptoms that require immediate attention (i.e. severe depression, anxiety attacks, suicidality etc.).	<ul style="list-style-type: none"> <li>• There is a documented procedure for clients to follow if they need after-hours assistance and is included in the client orientation process.</li> <li>• There are written policies and procedures for staff to follow in psychiatric or medical emergencies.</li> <li>• Policies and procedures define emergency situations, and the responsibilities of key staff are identified.</li> <li>• There is a procedure in place for training staff to respond to emergencies.</li> </ul>
<b>4. MONTHLY NARRATIVE REPORTS</b>	
ESS programs are required to submit fiscal vouchers in conjunction with monthly narrative and AIRS data reports.	<ul style="list-style-type: none"> <li>• Narrative reports must be submitted monthly and adhere to the prescribed format.</li> <li>• Monthly reports should highlight progress towards meeting program goals.</li> <li>• For Medical Transportation Programs: <ul style="list-style-type: none"> <li>○ Tracking the type of Ryan White fundable service client attended, origin of the trip, destination of the trip, and mileage per trip (for taxis, gas cards, or car transport) is the responsibility of the program and will be reported in the monthly narrative report.</li> </ul> </li> <li>• Copies of the following AIRS reports must be submitted with monthly narrative reports: <ul style="list-style-type: none"> <li>○ “Summary of Services by Service Category and Encounter Type”</li> <li>○ “Main Aggregate Report – Active Clients”</li> </ul> </li> </ul> <p><b>Fiscal vouchers will not be processed without accompanying monthly reports.</b></p>
<b>5. DOCUMENTATION</b>	
ESS programs must maintain records for all clients enrolled in the program and make them available for review by NYSDOH AI staff.	<p>Client records must contain the following:</p> <ul style="list-style-type: none"> <li>• ESS enrollment date</li> <li>• Proof of HIV status</li> <li>• All ESS forms (see Attachment 4): Intake (including AIRS Intake Form), Assessment/Reassessment, Service Plans, Health Education Screenings, Health Education Plans, Case Closure, Transportation Assessment, and all other forms developed for recording any and all services provided.</li> <li>• Progress Notes (content requirements can be found in <b>Section IV. Service Requirements</b> under each specific service.)</li> </ul>

<b>6. CULTURAL AND LINGUISTIC COMPETENCE</b>	
<p>ESS programs must be designed with an understanding of the differences that derive from language, culture, race-ethnicity, religion, age, gender, income, poverty, sexual orientation, and developmental characteristics.</p>	<ul style="list-style-type: none"> <li>• Programs will promote training and educational opportunities for funded staff and peers that increase cultural and linguistic competence, and strengthen their ability to provide quality services to all PLWHA including those of special and underserved populations (e.g., immigrants and migrants, MSM, MSM/IDU of color).</li> <li>• All materials will be in a format that promotes health literacy.</li> </ul>
<b>7. HEALTH LITERACY UNIVERSAL PRECAUTIONS GUIDING PRINCIPLE</b>	
<p>ESS programs will integrate health literacy universal precautions into their program policies, staff training requirements, care models, and quality improvement activities to ensure client understanding at all points of contact.</p> <p>The AIDS Institute recognizes the importance of health literacy universal precautions to improve quality, reduce costs and to reduce health disparities.</p>	<ul style="list-style-type: none"> <li>• Programs will incorporate health literacy universal precautions.</li> <li>• Health literacy universal precautions is defined as an approach that               <ol style="list-style-type: none"> <li>1) assumes <u>everyone</u> could use help with health information,</li> <li>2) considers it the responsibility of the health care system to make sure patients understand,</li> <li>3) focuses on making health care environments more literacy friendly and training providers to always communicate effectively.</li> </ol> </li> </ul> <p>For more information on health literacy universal precautions, see the following journal articles.</p> <ul style="list-style-type: none"> <li>• <a href="#">Ten Attributes of Health Literate Health Care Organizations</a> – full article</li> <li>• <a href="#">A Proposed 'Health Literate Care Model' Would Constitute A Systems Approach To Improving Patients' Engagement In Care</a> – abstract. The full journal article is available at: <a href="http://www.health.ny.gov/diseases/aids/health_literacy/index.htm">http://www.health.ny.gov/diseases/aids/health_literacy/index.htm</a></li> </ul>
<b>8. QUALITY MANAGEMENT</b>	
<p>ESS programs are expected to develop and implement a quality management (QM) plan for ESS services that monitors and evaluates program processes, quality of care and outcomes.</p>	<p>The QM plan:</p> <ul style="list-style-type: none"> <li>• includes sound evaluation practices and incorporates planned activities that measure and assess goals, objectives, outcomes and processes of the program</li> <li>• Defines measurable outcomes;</li> <li>• Uses data to measure progress toward established benchmarks and program objectives;</li> <li>• Guides the continuous quality improvement process;</li> <li>• Is reviewed and updated as needed by the program's quality management team and approved by the Executive Director and ESS staff;</li> <li>• Includes program objectives, quality management team composition, quality management indicators, and quality improvement methods; and</li> <li>• Involves agency staff, program staff, peers and clients participate in the ongoing planning, development, revisions, and evaluation of the program services.</li> </ul>
<b>9. LINKAGES AND COORDINATION</b>	
<p>ESS programs will maintain linkages and coordinate care with regional health care and support service providers.</p>	<ul style="list-style-type: none"> <li>• Establish clear bi-directional linkages with all providers involved in the client's care. This includes all levels of medical and specialty care, behavioral health, entitlements and other community support providers.</li> <li>• Medical Transportation providers are expected to have agreements</li> </ul>

<p>Linkages are essential to facilitating referrals, ongoing communication, monitoring, and coordination of services through the regular receipt and provision of relevant information between the case manager, health educator, peers, and all service providers.</p>	<p>with providers for reasons relevant to the service being provided (e.g., verification of attendance at appointments for which conveyance was provided).</p>
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**10. SUPERVISION AND TRAINING**

<p>ESS programs will hire qualified staff and ensure that appropriate orientation, supervision and professional development opportunities are available.</p>	<ul style="list-style-type: none"> <li>• Staff and peers receive routine supervision, are appropriately oriented to the agency and the ESS program; and receive HIV/AIDS confidentiality training upon hire.</li> <li>• Programs will support staff and peer skill development by ensuring availability and access to educational training resources and materials.</li> <li>• Program staff and peers participate in any and all meetings and trainings required by the AIDS Institute.</li> </ul>
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## VIII. APPENDICES

### ATTACHMENT 1

#### HRI CONTRACT ATTACHMENT B – PROGRAM SPECIFIC CLAUSES – AIDS INSTITUTE

**1) Maximum Reimbursable Amount:**

- a) In the event that a **Maximum Reimbursable Amount** has been specified on the face page of this Agreement, it is understood and accepted by the Contractor that while the Budget attached hereto as Exhibit B is equal to the Total Contract Amount specified on the face page of this Agreement, the aggregate of all allowable costs reimbursed under this reimbursement contract ***will not exceed the Maximum Reimbursable Amount***. The Contractor may incur allowable costs in all categories as noted in the Budget Exhibit B; however, the aggregate amount reimbursed by HRI under this Agreement shall not exceed the Maximum Reimbursable Amount. In the event the Maximum Reimbursable Amount is increased by HRI, the Contractor will be notified in writing by HRI.

**2) Confidentiality:**

- a) CONTRACTOR understands that the information obtained, collected or developed during the conduct of this agreement may be sensitive in nature. The Contractor hereby agrees that its officers, agents, employees and subcontractors shall treat all client/patient information which is obtained through performance under the Agreement, as confidential information to the extent required by the laws and regulations of the United States Codified in 42 CFR Part 2 (the Federal Confidentiality Law) and Chapter 584 of the laws of the State of New York (the New York State HIV Confidentiality Law) and the applicable portions of the New York State Department of Health Regulation Part 63 (AIDS Testing and the Confidentiality of HIV Related Information.)
- b) CONTRACTOR further agrees that its officers, agents, employees and subcontractors shall comply with the New York State Department of Health AIDS Institute policy “Access to and Disclosure of Personal Health Related Information,” attached hereto and made a part hereof as Attachment D.

**3) Evaluation and Service Coordination**

- a) CONTRACTOR shall participate in program evaluation activities conducted by the AIDS Institute at the Evaluation Frequency specified in Exhibit C. These activities will include, but not be limited to, the collection and reporting of information specified by the AIDS Institute.
- b) For Direct Service Contracts Only - CONTRACTOR shall coordinate the activities being funded pursuant to this work plan with other organizations within its service area providing HIV-related services including, but not limited to: community entities that provide treatment adherence services, including treatment education, skills building and adherence support services; service providers; community based organization, HIV Special Needs Plans; and other agencies providing primary health care to assure the non-duplication of effort being conducted. The Contractor shall develop linkages with these providers in order to effectively coordinate and deliver services to the targeted population. As part of the reporting requirements, the Contractor will advise the AIDS Institute as to the coordination of efforts being conducted and the linkage arrangements agreed to.

**4) Publication:**

- a) All written materials, pictorials, audiovisuals, questionnaires or survey instruments and proposed educational group session activities or curricula developed or considered for purchase by the Contractor relating to this funded project must be reviewed and approved in writing by the NYS Department of Health AIDS Institute Program Review Panel prior to dissemination and/or publication. It is agreed that

such review will be conducted within a reasonable timeframe. The Contractor must keep on file written notification of such approval.

- b) In addition to the sponsor attributions required under paragraph 10, “Publications” of “Attachment A General Terms and Conditions”, any such materials developed by the Contractor will also include an attribution statement, which indicates the intended target audience and appropriate setting for distribution or presentation. Examples of statements are attached with Attachment E.

## 5) Fiscal Systems

- a) CONTRACTOR shall meet contracted programmatic and fiscal requirements including (i) financial reports that track expenditures as specified by HRI; (ii) financial and provider policies and procedures manual that meet HRI program requirements; and (iii) flexible fiscal reporting systems that allow the tracking of obligated balances and carryover funds and detail service reporting of funding sources.
- b) CONTRACTOR shall ensure adequacy of agency fiscal systems to generate budgets and expenditure reports including (i) accounting policies and procedures; (ii) budgets; and (iii) accounting system.
- c) CONTRACTOR shall (i) maintain file documentation of all payroll records, tax records, invoices, accounts payable and expenditure data related to this award and (ii) make the documentation available for HRI review upon request.
- d) CONTRACTOR shall provide HRI personnel access to (i) accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports; (ii) all financial policies and procedures, including billing, collection, purchasing and procurement policies; and (iii) accounts payable systems and policies.
- e) CONTRACTOR shall (i) provide timely properly documented invoices; (ii) submit invoices on time with required documentation; (iii) maintain data documenting reimbursement periods, including monthly bank reconciliation reports and receivables aging report; (iv) inform HRI of any situation that will make it impossible or unlikely to fully spend this award; (v) track and provide accurate and timely reporting of position vacancies and unspent funds to HRI; and (vi) carry out monthly monitoring of expenses to detect and implement cost saving strategies.
- f) CONTRACTOR shall maintain a file documenting all travel expenses paid under this contract.
- g) CONTRACTOR shall submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.
- h) CONTRACTOR shall document all requests for and approval of budget revisions.

## 6) Documentation

- a) CONTRACTOR shall (i) develop and maintain a current, complete and accurate asset inventory list that lists purchases of equipment of a cost of more than \$1000 per unit and all computers and AIRS related equipment by funding source and make the list and schedule available to HRI upon request and (ii) implement adequate safeguards for all capital assets that assure they are used solely for authorized purposes.
- b) If applicable, CONTRACTOR shall establish policies and procedures that acknowledge the revisionary interest of the federal government over property improved or purchased with federal dollars and maintain file documentation of these policies and procedures for HRI review.
- c) CONTRACTOR shall include in personnel manual and employee orientation information on regulations that forbid lobbying with contract funds.
- d) If applicable, CONTRACTOR shall use purchasing policies and procedures that meet federal requirements.
- e) If applicable, CONTRACTOR shall establish policies and procedures to ensure compliance with all applicable federal and local statutes and regulations governing contract award and performance including (i) state law and procedures when awarding and administering subcontracts; (ii) ensure that every subcontract includes any clauses required by federal statute and executive orders and their implementing regulations; (iii) ensure that subcontract agreements specify requirements impose upon subcontractors by

federal statute and regulation; (iv) ensure appropriate retention of and access to records and (v) ensure that any advances of grant funds to subcontractors substantially conform to the standards of timing and amount that apply to cash advances by federal agencies.

- f) CONTRACTOR shall prepare and provide to HRI upon request program and fiscal staff resumes, job descriptions, a staffing plan, and an organizational chart.
- g) CONTRACTOR shall maintain and review file documentation of (i) Corporate Compliance Plan; (ii) Personnel Policies; (iii) Code of Ethics or Standards of Conduct; (iv) Bylaws and Board Policies including Board Ethics; (v) business conduct practices; and (vi) file documentation of any employee or Board Member in violation of or with a complaint of violation of the Code of Ethics or Standards of Conduct and its resolution.
- h) CONTRACTOR shall have adequate policies and procedures to discourage soliciting cash or in-kind payments for (i) awarding contracts; (ii) referring clients; (iii) purchasing goods or services; and (iv) submitting fraudulent billings.
- i) CONTRACTOR shall also have employee policies that discourage (i) the hiring of persons being investigated by Medicare or Medicaid and (ii) large signing bonuses.

## 7) Allocations

- a) CONTRACTOR shall (i) ensure that budgets and expenses conform to federal cost principles; and (ii) ensure fiscal staff familiarity with applicable federal regulations.
- b) CONTRACTOR shall (i) make available to HRI very detailed information on the allocation and costing of expenses for services provided; and (ii) reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.
- c) CONTRACTOR shall (i) have in place policies and procedures to determine allowable and reasonable costs; (ii) have in place reasonable methodologies for allocating costs among different funding and (iii) make available policies, procedures and calculations to HRI on request.
- d) CONTRACTOR shall (i) establish and consistently use allocation methodology for employee salaries and wages where employees are engaged in activities supported by several funding sources and (ii) make allocation methodology available to HRI upon request.

## 8) Audits

- a) CONTRACTOR shall (i) conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds); (ii) request a management letter from auditor; (iii) submit the audit and management letter to HRI; (iv) prepare and provide auditor with income and expense reports that include payer of last resort verification; (v) have in place financial policies and procedures that guide selection of an auditor; (vi) submit to HRI the CONTRACTOR's response to any reportable conditions on the audit.

## 9) Other

- a) CONTRACTOR shall cooperate with any federal investigation regarding funding under this contract.
- b) For Direct Service Contracts Only - CONTRACTOR shall ensure that the facility where services are provided is accessible by public transportation or provide for transportation assistance.
- c) For Direct Service Contracts Only - CONTRACTOR (i) shall maintain file materials documenting Consumer Advisory Board (CAB) membership and meetings including minutes; (ii) regularly implement client satisfaction survey tool, focus groups and or public meetings with analysis and use of results documents and (iii) maintain visible suggestion box or other client input mechanism.
- d) For Direct Service Contracts Only - CONTRACTOR shall maintain files documenting provider activities for the promotion of HIV services to low income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements.
- e) For Direct Service Contracts Only - CONTRACTOR shall to the extent possible provide services in settings that are accessible to low-income individuals with HIV disease.

**10) For Direct Service Contracts Only - Client Eligibility and Recertification Requirements**

- a) CONTRACTOR shall (i) document that the process for establishing eligibility, assessment and reassessment takes place within time frames established by the New York State Department of Health; (ii) document that all staff involved in eligibility determination have participated in required training; and (iii) provider client data reports are consistent with eligibility requirements specified by funder which demonstrates eligible clients are receiving allowable services.
- b) CONTRACTOR must document client eligibility immediately upon enrollment in the funded program. Client eligibility verification includes; HIV status, New York State residency, Income, and Insurance Status. Specific examples of acceptable forms of documentation are listed below.
  - i) To maintain eligibility for services, clients must be recertified at least every six months (except for HIV status, see below). The primary purpose of the recertification process is to ensure that an individual continues to meet eligibility requirements for the program.
  - ii) There is flexibility in the recertification process.
    - (1) It is required that at least once a year the recertification procedures include the collection of in-depth supporting documentation, similar to that collected at the initial eligibility determination.
    - (2) However, at one of the two required certifications during a year, contractors may accept client self-attestation, or “verification” that an individual’s income, residency, or insurance status continues to comply with the eligibility requirements.
    - (3) Appropriate supporting documentation is always required for any changes in status that may occur throughout the year.
  - iii) Contractors must be aware of these requirements, and contract managers must review documentation of client eligibility during monitoring.
- c) **HIV Status**
  - i) Contractors must document client eligibility immediately upon client enrollment into the program. Client files must include primary documentation of HIV positive status.
  - ii) Acceptable documentation includes:
    - (1) HIV antibody test results and/or
    - (2) Documentation of detectable HIV viral load results and/or
    - (3) Physician (M.D., N.P., P.A.) signed/written statements/progress notes and/or
  - iii) If documentation is not in the client’s file, a reference to the primary documentation is acceptable. This may be in the form of a certified referral or a notation that eligibility has been confirmed, including the name of the person/organization verifying eligibility, date, and nature and location of primary documentation.
  - iv) 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 such time as the client is indicated as “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.
  - v) Non-infected individuals may be appropriate candidates for services in limited situations, but these services for non-infected individuals must always benefit a person with HIV infection. Funds may be used for services to individuals not infected with HIV only in the circumstances described below.
    - (1) The service has as its primary purpose enabling the non-infected individual to participate in the care of someone with HIV disease or AIDS. Examples include caregiver training for in-home medical or support service; psychosocial support services, such as caregiver support groups; and/or respite care services that assist non-infected individuals with the stresses of providing daily care for someone who is living with HIV disease.

- (2) The service directly enables an infected individual to receive needed medical or support services by removing an identified barrier to care. Examples include child care for children, while an infected parent secures medical care or support services.
- (3) The service promotes family stability for coping with the unique challenges posed by HIV/AIDS. Examples include mental health services that focus on equipping uninfected family members, and caregivers to manage the stress and loss associated with HIV/AIDS, and short-term post death bereavement counseling.
- (4) Services to non-infected clients that meet these criteria may not continue subsequent to the death of the HIV-infected family member, beyond the period of short-term bereavement counseling.

#### d) Residency

- i) Contractors must document client eligibility immediately upon client enrollment into the program. 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.
- ii) Acceptable forms of documentation include:
  - (1) Current lease
  - (2) Current driver's license
  - (3) Government issued ID card
  - (4) Current voter registration card
  - (5) Current Notice of Decision from Medicaid
  - (6) U.S. Immigration, naturalization or citizenship card with current address
  - (7) Fuel/utility bill (within past 90 days)
  - (8) Phone bill (within past 90 days)
  - (9) Rent receipt (within past 90 days)
  - (10) Pay stubs or bank statement with client's name and address (within past 90 days)
- iii) If the client has a PO Box where he/she receives mail, information documenting the client's physical address must be included to document New York State residency.
- iv) If a client lives with someone and has none of the items above in the client's name, proof of their residency and a letter stating that the client lives with them will be needed.
- v) 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 or annual recertification process must be recorded in the client's record.

#### e) Income

- i) Contractors must document client eligibility immediately upon client enrollment into the program.
- ii) Financial eligibility is based on 435% of the Federal Poverty Level (FPL): 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/index.shtml>
  - (1) **Income Source** – Include all sources of income for the client and all household members. This is income only for household members with whom the client has a legally responsible relationship (for example, spouse or child but not uncle, cousin or roommate). Documentation of income is required.
  - (2) **For Wage Earners** - Income should be documented by copies of pay stubs for the past 30 days. If you cannot get a paystub, a notarized letter from the employer showing gross pay for the past 30 days is acceptable.
  - (3) **Self-employed Individuals** – Income determination should be based on business records for the preceding three month period.

- (4) **Rental Income** - Income received from rental property can be documented by a copy of the lease or most recent income tax return.
  - (5) **All Other Income** - Copies of SSD/SSI award letters, unemployment checks, Social Security checks, pension checks, etc. from the past 30 days can be used as proof of other types of income.
  - (6) **No Income, Supported by Others** - If the client has no income and is supported by a friend or family member, obtain a letter from that friend or family member stating how they support the client.
- iii) 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.
- f) **Insurance Status**
- i) Contractors must screen clients for eligibility to receive health care coverage through other programs (e.g., Medicaid, Medicare, VA benefits, private health insurance, employer sponsored insurance, HIV Uninsured Care Program, New York State of Health Marketplace). Contractors must have policies and procedures in place addressing these screening requirements. Contract managers will review these policies and procedures as well as documentation of screening activities and client eligibility during contract monitoring.
  - ii) 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.

## 11) Allowable Costs

- a) CONTRACTOR shall maintain documentation of policies that forbid use of contract funds for cash payments to service recipients.
- b) For vehicle purchases, CONTRACTOR shall seek HRI assistance in obtaining written approval and maintain documentation of such approval in file. Three quotes are required.
- c) CONTRACTOR shall prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities.

## 12) Unallowable Costs: Funds cannot be used to support the following services:

- (1) HIV prevention/risk reduction for HIV-negative or at-risk individuals.
- (2) Syringe exchange programs.
- (3) HIV counseling and testing.
- (4) Employment, vocational rehabilitation, or employment-readiness services.
- (5) Art, drama, music, dance, or photography therapy.
- (6) Social, recreational, or entertainment activities. **Federal funds cannot be used to support social, recreational or entertainment activities.** Ryan White funds cannot be used to support amusement, diversion, social activities, or any costs related to such activities, such as tickets to

- shows, movies or sports events, meals, lodging, transportation, and gratuities. Movie tickets or other tickets cannot be used as incentives. Funds should NOT be used for off-premise social/recreational activities or to pay for a client's gym membership. Ryan White funds cannot support parties, picnics, structured socialization, athletics, etc.
- (7) Non-client-specific or non-service-specific advocacy activities.
  - (8) Services for incarcerated persons, except transitional case management, per HRSA policy Notice 7-04.
  - (9) Costs associated with operating clinical trials.
  - (10) Funeral, burial, cremation or related expenses.
  - (11) Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. This restriction does not apply to vehicles operated by organizations for program purposes.
  - (12) Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
  - (13) Criminal defense or class action suits unrelated to access to services eligible for funding under Ryan White.
  - (14) In no case may Ryan White HIV/AIDS Program funds be used to make direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Grantees are advised to administer voucher programs in a manner which assures that vouchers cannot be used for anything other than the allowable service, and that systems are in place to account for disbursed vouchers.
  - (15) Inpatient services.
  - (16) Clothing.
  - (17) Installation of permanent systems for filtration of all water entering a private residence.
  - (18) Professional licensure or to meet program licensure requirements.
  - (19) Broad-scope awareness activities about HIV services which target the general public.
  - (20) **Fund raising.** Federal funds cannot be used for organized fund raising, including financial campaigns, solicitation of gifts and bequests, expenses related to raising capital or contributions, or the costs of meetings or other events related to fund raising or other organizational activities, such as the costs of displays, demonstrations, and exhibits, the cost of meeting rooms, and other special facilities used in conjunction with shows or other special events, and costs of promotional items and memorabilia, including gifts and souvenirs. These costs are unallowable regardless of the purpose for which the funds, gifts or contributions will be used.
  - (21) Transportation for any purpose other than acquiring medical services or acquiring support services that are linked to medical outcomes associated with HIV clinical status. Transportation for personal errands, such as grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings is not allowed.
  - (22) Pediatric developmental assessment and early intervention services, defined as the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children.
  - (23) Permanency planning defined as the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
  - (24) Voter registration activities.
  - (25) Costs associated with incorporation.
  - (26) Herbal supplements/herbal medicines.

- (27) Massage and related services.
- (28) Reiki, Qi Gong, Tai chi and related activities.
- (29) Relaxation audio/video tapes.
- (30) Yoga, yoga instruction, yoga audio/video tapes, yoga/exercise mats.
- (31) Acupuncture services.
- (32) Buddy/companion services.
- (33) International travel.
- (34) Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility.
- (35) Lobbying activities.
- (36) Funds may not be used for household appliances, pet foods or other non-essential products.
- (37) Funds cannot be used to support materials designed to promote intravenous drug use or sexual activity.
- (38) Purchase of vehicle without approval.
- (39) Pre-exposure prophylaxis.

**13)** For Direct Service Contracts Only - CONTRACTORS are expected to provide documented, fundable services to eligible clients and to clearly define the scope and nature of such services in the contract work plan. Contract work plans and duties descriptions of staff supported by these funds will be reviewed to ensure that they include only those activities that are fundable under this contract.

## ATTACHMENT 2

### HRI CONTRACT ATTACHMENT “B-1” RYAN WHITE GUIDANCE FOR PART B DIRECT SERVICE SUBCONTRACTORS

This guidance sets forth requirements related to AIDS Institute Ryan White Part B contracts as stipulated in the Ryan White HIV/AIDS Treatment Extension Act and as mandated by HRSA policy and New York State policy. The following information provides guidance for contractors in developing budgets and work plans. Ryan White Part B contracts **must** adhere to these requirements. This guidance includes information on allowable services, client eligibility, time and effort reporting, administration, and payer of last resort requirements. Please note that these policies may not be applicable to Ryan White Part A contracts administered by PHS.

#### **Ryan White Service Categories**

The Ryan White law limits the persons eligible for Ryan White services and limits the services that are allowable with Ryan White funds. Activities supported and the use of funds appropriated under the law must be in accordance with legislative intent, federal cost principles, and program-specific policies issued by the federal Health Resources and Services Administration (HRSA). HRSA policy related to Ryan White Parts A and B states that no service will be supported with Ryan White funds unless it falls within the legislatively defined range of services. In addition, the law stipulates that Ryan White is the “payer of last resort” (see payer of last resort section on page 4). In conducting program planning, developing contracts, and overseeing programs, you must comply with legislative intent and HRSA policy regarding allowable services and payer of last resort requirements.

Ryan White funded medical and support services must be provided in settings that are accessible to low income individuals with HIV disease.

By receiving Part B funds, the contractor agrees to participate, as appropriate, in Ryan White HIV/AIDS Treatment Extension Act initiatives. The contractor agrees that such participation is essential in meeting the needs of clients with HIV as well as achieving the overall goals and objectives of the Ryan White HIV/AIDS Treatment Extension Act.

Ryan White Part B funds may be used to support the following services:

#### **CORE SERVICES**

- 1. Mental health services for HIV-positive persons.** Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, including individual and group counseling, based on a detailed treatment plan, provided by mental health professionals licensed by the NYS Department of Education and the Board of Regents to practice within the boundaries and scope of their respective profession. This includes Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Masters prepared Psychiatric Registered Nurses, and Licensed Clinical Social Workers. All mental health services must be provided in accordance with the AIDS Institute Mental Health Standards of Care.
- 2. Medical case management services (including treatment adherence)** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments are key components of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the care plan at least every 6 months, as necessary during the enrollment of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. Medical case management services must be provided by trained professionals who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. Medical case management may be provided in a variety of medical settings, including community health centers, County Departments of Health, hospitals, or other

Article 28 facilities. All medical case management services must be provided in accordance with AIDS Institute medical case management standards.

**SUPPORT SERVICES, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS.** Support services must be shown to improve clinical outcomes. Support services must facilitate access to care. Allowable support services are:

3. **Case management (non-medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed support services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. In accordance with HRSA HAB policy notice 07-04, this includes transitional case management for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning, or who are in the correctional system for a brief period, which would not include any type of discharge planning. All non-medical case management services must be provided in accordance with AIDS Institute non-medical case management standards.
4. **Emergency financial** - Ryan White HIV/AIDS Program funds may be used to provide Emergency Financial Assistance (EFA) as an allowable support service.
  - a. The decision-makers deliberately and clearly must set priorities and delineate and monitor what part of the overall allocation for emergency assistance is obligated for transportation, food, essential utilities, and/or prescription assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.
  - b. In addition, Grantees and planning councils/consortia must develop standard limitations on the provision of Ryan White HIV/AIDS Program funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of Ryan White HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time
5. **Food bank/home-delivered meals** - Food and Meal Services assist with improving the nutrition status of the client while they develop the necessary skills to make appropriate food choices that will improve and/or maintain their health status. Nutrient dense, well balanced, and safe meals and food tailored to the specific dietary needs of PLWH/A can assist in maximizing the benefits of medical interventions and care. The food and meal services include home-delivered meals, congregate meals, pantry bags, and food gift cards/vouchers. Meals and pantry bags must provide culturally acceptable foods based on knowledge of the food habits and preferences of the target populations.
6. **Health education/risk reduction** -HIV education and risk reduction services include short term individual and/or group level activities to address medical and/or health related education intended to increase a client's knowledge of and participation in their health care, address secondary HIV prevention, improve health, and decrease the risk of transmission of HIV. Education and risk reduction services should be structured to enhance the knowledge base, health literacy and self efficacy of HIV-infected persons in accessing and maintaining HIV medical services and staying healthy. Recreational and socialization activities are not included in this category.
7. **Housing services** are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.
8. **Linguistic services** include interpretation/translation services (both written and oral), provided to HIV-infected individuals (including non-English speaking individuals, and those who are deaf or hard of hearing) for the purpose of ensuring the client's access to medical care and to Ryan White fundable support services that have a direct impact on primary medical care. Funded providers must ensure linguistic services are provided by a qualified professional interpreter.
9. **Medical Transportation services** include conveyance services provided, directly or through voucher, to an eligible client so that he or she may access HIV-related health and support services intended to maintain the client in HIV/AIDS medical care. If this contract is funded under Catalog of Federal Domestic

Assistance Number 93.917 or 93.915, the contractor certifies that it will provide transportation services for eligible clients to medical and support services that are linked to medical outcomes associated with HIV clinical status. Transportation should be provided through: A contract(s) with a provider(s) of such services; Voucher or token systems, Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Ryan White HIV/AIDS Program funds, but should not in any case exceed the established rates for Federal Programs. Federal Joint Travel Regulations provide further guidance on this subject; Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or, Purchase or lease of organizational vehicles for client transportation programs. Note: Grantees must receive prior approval for the purchase of a vehicle.

10. **Outreach services** are programs that have as their principal purpose identification of people who know their status so that they may become aware of, and may be enrolled in care and treatment services, **NOT** HIV counseling and testing or HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.
11. **Psychosocial support services** are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups that improve medical outcomes, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.
12. **Referral for health care/supportive services** is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.
13. **Treatment adherence counseling** - Short term individual and/or group level activities used to provide HIV/AIDS treatment information, adherence counseling, monitoring, and other strategies to support clients in readiness to begin ARV treatment or maintain maximal adherence to prescribed HIV/AIDS treatment. Treatment adherence counseling activities are provided by non-medical personnel outside of the medical case management and clinical setting. The ultimate goal of treatment education is for a consumer to self-manage their own HIV/AIDS-related care. Self-management is the ability of the consumer to manage their health and health care autonomously, while working in partnership with their physician.

Ryan White funds may also be used to support training of providers delivering allowable services that is intended to improve medical outcomes and consumer education/training that is intended to improve medical outcomes.

### Payer of Last Resort

- Ryan White is payer of last resort. The Ryan White HIV/AIDS Treatment Extension Act requires that "...the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made with respect to that item or service under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or by an entity that provides health services on a prepaid basis." DSS program policy guidance No. 2 further states that at the individual client level, grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of Ryan White whenever possible. Ryan White funding may only be used for services that are not reimbursable by Medicaid, ADAP Plus or other third-party payers.
- The Contractor shall (i) maintain policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met; (ii) screen each client for insurance coverage and eligibility for third party programs, assist clients in applying for such coverage and document this in client files; and (iii) carry out internal review of files and billing system to ensure Ryan White resources are used only when a third party payer is not available.
- The Contractor shall (i) have billing, collection, co-pay and sliding fee policies that do not act as a barrier to providing services regardless of the clients ability to pay and (ii) maintain file of individuals refused services with reasons for refusal specified and any complaints from clients with documentation of complaint review and decision reached.
- The Contractor shall ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the payer of last resort requirement.

### **Medicaid Certification & Program Income**

- Contractors that provide Medicaid-eligible services pursuant to this agreement shall (i) participate in New York State's Medicaid program; (ii) maintain documentation of their Medicaid certification; (iii) maintain file of contracts with Medicaid insurance companies; and (iv) document efforts to obtain Medicaid certification or request waiver where certification is not feasible.
- The Contractor shall bill, track and report to HRI all program income (including drug rebates) pursuant to this agreement that are billed and obtained. Report of program income will be documented by charges, collections and adjustment reports or by the application of a revenue allocation formula.
- The Contractor shall (i) establish policies and procedures for handling Ryan White revenue including program income; (ii) prepare a detailed chart of accounts and general ledger that provide for the tracking of Ryan White revenue; and (iii) make the policies and process available for granted review upon request.

### **Client Charges**

The Ryan White HIV/AIDS Program legislation requires grantees and subgrantees to develop and implement policies and procedures that specify charges to clients for Ryan White funded services. These policies and procedures must also establish sliding fee scales and discount schedules for clients with incomes greater than 100% of poverty. The legislation also requires that individuals be charged no more than a maximum amount (cap) in a calendar year according to specified criteria.

Each subcontractor may adopt the following policy for use in their policies and procedures in order to satisfy this legislative requirement.

All clients receiving Ryan White Part B services must meet the following income eligibility requirements. Financial eligibility is based on 435% of the Federal Poverty Level (FPL). Clients above 435% of FPL are not eligible for services. FPL varies based on household size and is updated semi-annually. Financial eligibility is calculated on the gross income available to the household:

- If an individual's income is less than or equal to 100% of the Federal Poverty Level (FPL), the individual may not be charged for services.
- For individuals with income from 101% to 200% of the FPL, a nominal fee of \$5 will be charged per service visit. Cumulative charges in a calendar year can be no more than 5% of the individual's annual gross income. Once the 5% cap is reached, the individual may no longer be charged for services.
- For individuals with incomes from 201% to 300% of the FPL, a nominal fee of \$7 will be charged per service visit. Cumulative charges in a calendar year can be no more than 7% of the individual's annual gross income. Once the 7% cap is reached, the individual may no longer be charged for services.
- For individuals with income over 300% of the FPL, a nominal fee of \$10 will be charged per service visit. Cumulative charges in a calendar year can be no more than 10% of the individual's annual gross income. Once the 10% cap is reached, the individual may no longer be charged for services.

The following discounted fee schedule shall be applied to all individuals receiving a Ryan White Part B service as follows:

- For individuals with income from 101% to 200% of the FPL, a discount of \$5 will be applied to each charge per service visit.
- For individuals with income from 201% to 300% of the FPL, a discount of \$7 will be applied to each charge per service visit.
- For individuals with income over 300% of the FPL, a discount of \$10 will be applied to each charge per service visit.

Services must be provided to eligible clients without regard to either the ability of the individual to pay for such services or the current or past health conditions of the individuals to be served.

### **Time and Effort Reporting**

Contractors must have systems in place to document time and effort of direct program staff supported by all federal funds. New federal contractors must submit their written policies related to time and effort to HRI for approval. Most often, such systems take the form of a time sheet entry. These time and effort reporting procedures must clearly identify the percentage of time each staff person devotes to contract activities in accordance with the approved budget. The percent of effort devoted to the project may vary from month to month. The employee's time sheet must indicate the percent of effort the employee devotes to each particular project for a given time period.

The effort recorded on the time sheet must reflect the employee's funding sources, and the percent of effort recorded for Ryan White funds must match the percentage being claimed on the Ryan White voucher for the same time period. In addition, 100 percent of the employee's time must be documented. In cases where the percentage of effort of contract staff changes during the contract period, contractors must submit a budget modification request to the AIDS Institute.

On audit, contractors will be expected to produce this documentation. Failure to produce this documentation could result in audit disallowances. HRI also has the right to request back-up documentation on any vouchers if they choose to do so. Only indirect staff is not subject to time and effort reporting requirements. Such staff must be included in the indirect costs line, rather than in the salaries section.

### **Quality**

Ryan White Part B contractors are expected to participate in quality management activities as contractually required, at a minimum compliance with relevant service category standards of care and collection and reporting of data for use in measuring performance. Quality management activities should incorporate the principles of continuous quality improvement, including agency leadership and commitment, staff development and training, participation of staff from all levels and various disciplines, and systematic selection and ongoing review of performance criteria, including consumer satisfaction.

### **HRSA National Monitoring Standards**

The National Monitoring Standards (Standards) are designed to help Ryan White HIV/AIDS Program Part A and B (including AIDS Drug Assistance Program) grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. Requirements set forth in other sources are consolidated into a single package of materials that provide direction and advice to grantees for monitoring both their own work and the performance of service providers. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies, and guidance documents.

The Standards were developed by the Division of Service Systems (DSS) within the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) in response to several Office of Inspector General (OIG) and Government Accountability Office (GAO) reports. These reports identified the need for a specific standard regarding the frequency and nature of grantee monitoring of subgrantees and a clear HRSA/HAB Project Officer role in monitoring grantee oversight of subgrantees.

Grantees and Subgrantees are required to comply with the Standards as a condition of receiving Ryan White Part A and Part B funds. The Standards can be accessed by visiting:  
<http://www.hab.hrsa.gov/manageyourgrant/granteebasics.html>

### **Administration**

The Ryan White legislation imposes a cap on contractor administration. The legislative intent is to fund services and keep administrative costs to a minimum. Contractors shall ensure that expenses on administrative costs do not exceed 10% of the total grant.

Administrative expenses may be individually set and may vary; however, the aggregate total of a contractors administrative costs may not exceed the 10% limit. Administrative activities include:

- usual and recognized overhead activities, **including established indirect rates** for agencies;
- management oversight of specific programs funded under the RWHAP; and
- other types of program support such as quality assurance, quality control, and related activities (exclusive of RWHAP CQM).

**The portion of direct facilities expenses such as rent, maintenance, and utilities for areas primarily utilized to provide core medical and support services for eligible RWHAP clients (e.g., clinic, pharmacy, food bank, counseling rooms, areas dedicated to groups) are not required to be included in the 10% administrative cost cap.** Note: by legislation, all indirect expenses must be considered administrative expenses subject to the 10% cap.

For contractors funded by Ryan White Part B, the following programmatic costs are **not** required to be included in the 10% limit on administrative costs; they may be charged to the relevant service category directly associated with such activities specific to the contract:

- Biannual RWHAP client re-certification;
- The portion of malpractice insurance related to RWHAP clinical care;
- Electronic Medical Records (EMR) data entry costs related to RWHAP clinical care and support services;
- The portion of the clinic receptionist's time providing direct RWHAP patient services (e.g., scheduling appointments and other intake activities);
- The portion of medical waste removal and linen services related to the provision of RWHAP services;
- The portion of medical billing staff related to RWHAP services;
- The portion of a supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care, to clinicians, case managers, and other individuals providing services to RWHAP clients (would not include general administrative supervision of these individuals); and
- RWHAP clinical quality management (CQM). However, expenses which are clearly administrative in nature cannot be included as CQM costs.

The following items of expense **are considered administrative** and should be included in the column for administrative costs when completing the budget forms.

#### (A) Salaries

**Management and oversight:** This includes staff that has agency management responsibility but no direct involvement in the program or the provision of services.

**Finance and Contract administration:** This includes proposal, work plan and budget development, receipt and disbursement of contract funds, and preparation of programmatic and financial reports as required by the AIDS Institute.

A position **or** percentage of a position may be considered administrative. Examples of titles that are 100% administrative: Controller, Accounting Manager, Director of Operations, Bookkeeper, Accountant, Payroll Specialist, Finance Coordinator, Maintenance Worker, or Security Officer.

Examples of titles that may in part involve administrative duties: Deputy Executive Director; Program Manager, Program Coordinator, or Clinic Manager. With regard to supervision, the percentage of time devoted to supervising programmatic activities and/or providing overall direction to program activities should be considered programmatic.

In the example below, the Chief Operating Officer and Chief Administrative Officer have wholly administrative positions. As such the entire amount requested from the AIDS Institute for these salaries is transferred into the administrative cost line. The Clinic Manager position is 20% administrative so 20% of the requested salary is considered administrative. A calculation on the Salary budget form page will divide all administrative salaries by the total salaries.

This percentage in the example below (9.93%) may be applied to items in the miscellaneous category that may be shared by program and administrative staff.

#### **Administrative Cost Updates:**

AIRS Data entry staff are **not** required to be included in the 10% limit on Administrative Costs for data entry related to core medical and support services provided to Ryan White HIV/AIDS Program (RWHAP) clients.

Some **examples** based on the recent updates are:

- A Receptionist's time providing direct RWHAP patient services is not required to be counted against the 10% administrative cost limit.
- A Supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities is not required to be included in the 10% administrative cost limit.

Job descriptions provided must describe the position's involvement with these activities in order to justify the charges.

Position Title/Incumbent Name(s) <small>List only those positions funded on this contract. If salary for position will change during the contract period, use additional lines to show salary levels for each period of time. If additional space is needed, copy this page.</small>	Hours Worked Per Week <small>Hours worked per week, regardless of funding source.</small>	Annual Salary <small>Salary for 12 months, regardless of funding source.</small>	# of months or pay periods funded on this contract	% of effort worked on this contract	Amount Requested from AIDS Institute <sup>(1)</sup> <small>Col 3 x Col 4 x Col 5 12 mos. or 26 pp</small>	Third Party Revenue <small>Show anticipated use of revenue generated by this contract. (Medicaid and ADAP Plus)</small>	Administrative Costs <small>Includes administrative staff salaries supported by this contract. <sup>(2)</sup></small>
Director of Case Mgt and Treatment Adherence	35	\$65,000	12	75.00%	\$48,750		
Chief Operating Officer	35	\$80,000	12	4.00%	\$3,200		\$3,200
Chief Administrative Officer	35	\$72,000	12	4.00%	\$2,880		\$2,880
Case Manager I	35	\$45,000	12	100.00%	\$45,000		
Clinic Manager	35	\$30,000	12	100.00%	\$30,000		\$6,000
Data Entry	35	\$29,000	12	20.00%	\$5,800		
IT Specialist	35	\$30,000	12	4.00%	\$1,200		\$1,200
<b>SUBTOTAL</b>					<b>\$136,830</b>		<b>\$13,280</b>
<b>Notes:</b>							<b>9.71%</b> <sup>2</sup>

**(B) Fringe**

The fringe rate should be applied to the amount of staff salaries devoted to administration (\$12,400 in the above example) in order to calculate the amount of administrative fringe benefits. The summary budget form will calculate this amount once the administrative salaries have been identified on the salary page and the fringe rate has been entered on the fringe page.

**(C) Supplies**

All funds budgeted for office supplies are considered administrative. Supplies such as educational or clinical materials would be considered programmatic. The administrative supply amount should be entered directly on the supply budget form.

**(D) Travel**

Travel pertaining to the financial operations or overall management of the organization is considered administrative. Client travel or travel of program staff to training would be considered programmatic. The administrative travel amount should be entered directly on the travel budget form.

**(E) Equipment**

Equipment purchased for administrative staff or for the financial operations or overall management of the organization is considered administrative. Equipment purchased for program staff or to support or enhance service delivery would be considered programmatic. The administrative equipment amount should be entered directly on the equipment budget form.

**(F) Miscellaneous**

Includes any portion of rent, utilities, telecommunications that are not directly related to core medical and support services provided to RWHAP clients. Audit expenses are considered 100% Administrative. Liability insurance can be considered both Administrative and programmatic if a methodology is included by the provider which demonstrates that a portion of the direct service is to RWHAP clients. The percentage of staff time devoted to administration (as calculated on the salary page) should be applied to items of expense shared by program and administrative staff (such as photocopiers, printers, and maintenance agreements). The amount of administrative telecommunications, space and miscellaneous other costs should be entered directly on the miscellaneous budget form.

Cell phone costs for 100% direct program staff will be considered programmatic expenses and should not be charged as administrative costs. If a portion of a staff salary is administrative, then that portion of their cell phone charges must be administrative.

**Examples:**

- A Case manager has a cell phone whose sole purpose is to use that cell phone for serving Ryan White positive clients would be considered 100% programmatic.
- A Clinic Manager has a cell phone and their administrative effort on the contract is 20%. This means that 20% of the cell phone cost must count towards the 10% administrative cost limit.

**(G) Subcontracts/Consultant**

Includes contractors who perform non-service delivery functions (bookkeepers, payroll services, accountants, security, maintenance, etc.) The administrative contractual amount should be entered directly on the subcontracts/consultants budget form.

**(H) Indirect**

100% of funds budgeted in the indirect line are administrative. Any contractor that has never received a Federal negotiated indirect cost rate may charge a de minimis rate of 10% of modified total direct costs. If chosen, this methodology once elected must be used consistently for all Federal awards until such time as a contractor chooses to negotiate for a rate, which they may apply to do at any time. The total amount of indirect costs requested should be transferred to the administrative cost line on the indirect costs budget form. **All indirect expenses must be considered administrative expenses subject to the 10% cap.**

The summary budget form will calculate a rate based on the entries made on each budget form. This rate must be 10% or less for Ryan White contractors. We recognize that some administrative resources are needed by contractors to support direct service programs; however, it is important to note that Ryan White funds are meant to support direct services rather than administration. Upon review of the budget, contract managers will work with you if necessary to reduce administrative costs.

### ATTACHMENT 3

#### **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 somewhat like 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 the DOH-2557 form, the DOH-5032 form 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>

## **ATTACHMENT 4**

### **ESS FORMS**

- A. INITIAL ASSESSMENT**
- B. QUARTERLY REASSESSMENT**
- C. HEALTH EDUCATION SCREENING FORM**
- D. SUGGESTED SERVICE PLAN FORMAT**

**Engagement and Supportive Services: Case Management and Health Education Program**  
**Initial Assessment** ESS Version 8-15

CLIENT ID # \_\_\_\_\_ INTAKE DATE \_\_\_\_\_

Referral Date \_\_\_\_\_ Referred by: \_\_\_\_\_  
(Referred to Case Management/Health Education Program)

Last Name _____		First Name _____		M.I. _____
Does client prefer to be referred to by any other name? _____				
Date of Birth _____		Age _____	Social Security# _____	
*Is client Medicaid eligible? _____				
Street/Apt. Number _____			City _____	
State _____	ZIP _____	County _____		
Phone ( ) _____		Cell phone ( ) _____		
Emergency Contact Number ( ) _____		Name/Relationship _____		
Is Emergency Contact aware of client's HIV status? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Client can be contacted (check all that apply) <input type="checkbox"/> At Home <input type="checkbox"/> By Mail <input type="checkbox"/> By Phone				
Is discretion required? _____				

**PRESENTING CASE MANAGEMENT SERVICE NEEDS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRESENTING HEALTH EDUCATION SERVICE NEEDS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For clients receiving Health Education only: are case management services provided through another agency?**     Yes     No

**If "yes", what agency/program is providing case management?** \_\_\_\_\_



**HOUSEHOLD COMPOSITION**

**Number of people in household (including client):**

Adults: \_\_\_\_\_

Children: \_\_\_\_\_

How does client describe his/her support system?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do household members, children or close supports have needs that impact client’s ability to access or maintain treatment or care?  Yes  No

Are there disclosure issues that can be assisted by case management?  Yes  No

Does the client have a functioning support system?  Yes  No

**PRIMARY INSURANCE**

Indicate all that apply:

- Medicare  Private Insurance  HMO/Managed Care  
 ADAP PLUS  Self Pay  Military  Other: \_\_\_\_\_

**SECONDARY INSURANCE**  None or  Yes, (check below)

- Medicare  Private Insurance  HMO/Managed Care  
 ADAP PLUS  Self Pay  Military  Other: \_\_\_\_\_

**Effective Date of Secondary Insurance:** \_\_\_\_\_

**HASA Phone # (NYC only)** \_\_\_\_\_ **HASA Worker** \_\_\_\_\_

**\*If client has Medicaid or is Medicaid eligible then she or he is also eligible for enrollment in a Health Home care management program and should be thus referred. Reasons for retaining a Medicaid/Medicaid eligible client in an ESS program should be compelling and clearly documented with the specific short term goal of transitioning the client into a Health Home program.**

Does the client need assistance with insurance for medical care?  Yes  No

**HIV STATUS/ HIV RISK History**

Has verification of HIV+ status been obtained?  Yes  No

Has the client been previously diagnosed with AIDS?  Yes  No When diagnosed? \_\_\_\_\_

Does client know how he/she was infected? Describe: \_\_\_\_\_

Has client experienced following in past 3 months: Recent STD  Yes  No Incarceration  Yes  No  
Sex Work  Yes  No Refused  Yes  No Not Asked  Yes  No

**MEDICAL**

**Does client have a current primary care provider?**  Yes  No

If “yes” please provide information below:

**Primary Medical Care**

Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Main Phone: \_\_\_\_\_

Case Manager/Social Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Recent Hospitalizations: \_\_\_\_\_

Last time saw doctor: \_\_\_\_\_ CD4 Count: \_\_\_\_\_ Date: \_\_\_\_\_

Viral Load: \_\_\_\_\_ Date: \_\_\_\_\_

Is client restricted to use of a specific medical provider/facility?  Yes  No

**If client does not have current primary care provider or has not engaged with his/her PCP, please describe client’s reasons for not being/staying in care:**

\_\_\_\_\_  
\_\_\_\_\_

**For female clients: Does client have a current OB/GYN provider?**  Yes  No

If “yes” please provide information below:

**OB-GYN Care**

Is client pregnant?  Yes  No If yes, is client receiving prenatal care?  Yes  No

N/A If yes, is client on anti-retroviral protocol?  Yes  No

Date of last Pap Smear: \_\_\_\_\_ Results: \_\_\_\_\_

OB/GYN Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_

**If client does not have current OB/GYN provider or has not engaged with one, please describe client’s reasons for not being/staying in care:**

\_\_\_\_\_  
\_\_\_\_\_

For clients without a Primary Care Physician: Was a referral for primary HIV care accepted?

Yes  No

If "Yes" please provide information below:

Provider/Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Main Phone: \_\_\_\_\_

Date of Initial Appointment: \_\_\_\_\_

If "No" why did client decline referral?

\_\_\_\_\_  
\_\_\_\_\_

**Other Health Related Information:**

(Please comment on the following, indicate if client has been prescribed medications for any of these conditions and/or if a referral is needed)

**TB Status:**

\_\_\_\_\_  
\_\_\_\_\_

**Hep C Status:**

\_\_\_\_\_  
\_\_\_\_\_

**Mental Health Status/History**

\_\_\_\_\_  
\_\_\_\_\_

**Substance Abuse Status/History**

\_\_\_\_\_  
\_\_\_\_\_

**Other Medical Conditions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pharmacy** (Specify): \_\_\_\_\_

Is client restricted to use of a pharmacy?  Yes  No

**Medications** (List all taken currently, e.g., HIV, TB, HCV, Psychotropics, etc.):

[Insert current Medications Page here. Please use list updated by BCSS approx every 6 mos]

**BASIC HIV EDUCATION**

Does client know how HIV is transmitted and prevention techniques?  Yes  No

Assess level of knowledge regarding:  Basic HIV transmission  Safer Sex/Use of Latex  
 Needle/Works Sharing  Effect of Drug/Alcohol Use on Risk

Does the client have difficulty keeping appointments or problems taking medications?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has a Health Education Screening been conducted?**

Yes  No

If "yes" please attach Health Education Screening form.

**TOTAL MONTHLY HOUSEHOLD INCOME SOURCE & BENEFITS**

Employment	_____	HIV/AIDS Service Administration	_____
Social Security	_____	Short Term Disability	_____
*SSI	_____	Survivor Benefits	_____
SSD	_____	Rent Supplement	_____
Child Support	_____	Veteran's Assistance	_____
Public Assistance	_____	Pension	_____
Disability Insurance	_____	Long Term Disability	_____
Alimony	_____	Unemployment Insurance	_____
Workman's Compensation	_____	Food Stamps	_____
Other:	_____		
		<b>Total Personal Monthly Income:</b>	_____

Additional monthly income from household members: \_\_\_\_\_

**Total monthly household income:** \_\_\_\_\_ **Annual household income (for AIRS) :** \_\_\_\_\_  
(Monthly income x 12)

\*SSI recipients are usually Medicaid eligible

Does the client have a regular source of income?  Yes  No  
 Does client have difficulty meeting monthly expenses?  Yes  No  
 Is the client linked to all income sources they are eligible for?  Yes  No  
 Does the client need assistance/advocacy in accessing entitlements?  Yes  No

**HISTORY OF INCARCERATION**

Has client been released from a correctional facility in the last 12 months?

Yes, when \_\_\_\_\_  No

How long incarcerated? \_\_\_\_\_ days/weeks/months/years

Is client currently on parole/probation?  Yes  No

If yes, name of Parole/Probation Officer: \_\_\_\_\_ phone: ( ) \_\_\_\_\_

Reason for incarceration: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

**DOMESTIC VIOLENCE**

Has the client ever been in an abusive relationship?  Yes  No – If yes, explain \_\_\_\_\_

\_\_\_\_\_

Does client feel safe in current living arrangement?  Yes  No - If no, explain: \_\_\_\_\_

\_\_\_\_\_

Does the client report ever feeling afraid that they or a family member/partner would resort to physical force when interacting with a significant other OR his/her children?  Yes  No – If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**OTHER NEEDS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is Peer Navigation recommended?**  Yes  No

If “yes” please describe reasons for recommending Peer Navigation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CASE DISPOSITION**

**Client ID#:** \_\_\_\_\_ **Client Name:** \_\_\_\_\_

**Accepted services:**

Case Management:  Yes  No      Case Manager: \_\_\_\_\_  
Health Education:  Yes  No      Health Educator: \_\_\_\_\_

- **Consent for Services form signed?**  Yes  No
- **Release of HIV Confidential Information form Signed?**  Yes  No

**Documents requested for client to collect and return with:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMEDIATE REFERRALS MADE:** (include contact name)

Hospital/Clinic: \_\_\_\_\_ For: \_\_\_\_\_  
Agency: \_\_\_\_\_ For: \_\_\_\_\_  
Agency: \_\_\_\_\_ For: \_\_\_\_\_  
Internal: \_\_\_\_\_ For: \_\_\_\_\_  
Internal: \_\_\_\_\_ For: \_\_\_\_\_

---

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



# Engagement and Supportive Services: Case Management and Health Education Quarterly Reassessment

CLIENT ID # \_\_\_\_\_

INTAKE DATE \_\_\_\_\_

90 Day Re-assessment       180 Day Re-assessment       270 Day Re-assessment

## CHANGES IN LIVING SITUATION

Please enter any changes in address, living situation, household composition, and income status.

## INSURANCE

Please enter any changes in insurance coverage. Has client become \*Medicaid eligible?

# Engagement and Supportive Services: Case Management and Health Education Quarterly Reassessment

## ENGAGEMENT IN CARE

For the previous three months:

List all scheduled medical appointment dates: \_\_\_\_\_

How many missed appointments were there? \_\_\_\_\_

Most recent viral load (Reported every six months): Date \_\_\_\_\_ Results \_\_\_\_\_

Most recent CD4 count (Reported annually): Date \_\_\_\_\_ Results \_\_\_\_\_

Was information verified?  Yes  No

Please describe client's current level of engagement in care: \_\_\_\_\_

## TREATMENT MANAGEMENT

During the last three months, using the scale below, how would client rate his/her adherence to treatment (Underline number):

1    2    3    4    5    6    7    8    9    10

Missed doses daily                      Missed doses weekly                      Never missed doses

What are the client identified barriers to medication adherence?

\_\_\_\_\_

# Engagement and Supportive Services: Case Management and Health Education Quarterly Reassessment

## CASE MANAGEMENT GOALS

Have any case management goals been met? (please describe) \_\_\_\_\_

What are the continuing goals? \_\_\_\_\_

Are there new goals? (please describe) \_\_\_\_\_

Has service plan been updated?  Yes  No (If Yes please attach updated service plan)

Briefly describe client's overall progress:

\_\_\_\_\_

## HEALTH EDUCATION GOALS

Have any health education goals been met? (please describe) \_\_\_\_\_

What are the continuing goals? \_\_\_\_\_

Are there new goals? (please describe) \_\_\_\_\_

Has education plan been updated?  Yes  No (If Yes please attach updated education plan)

Briefly describe client's overall progress:

\_\_\_\_\_

**Engagement and Supportive Services:  
Case Management and Health Education  
Quarterly Reassessment**

**CARE COORDINATION**

Please describe any efforts to coordinate services with other providers. Include case conferences and referrals made.

\_\_\_\_\_

**COORDINATION WITH ESS HEALTH EDUCATOR**

Was a case conference conducted with the Health Educator?  Yes  No

If "Yes" please describe general outcomes and goals:

\_\_\_\_\_

**Engagement and Supportive Services:  
Case Management and Health Education  
Quarterly Reassessment**

**\*MEDICAID ELIGIBLE CLIENTS**

If the client is now Medicaid eligible he/she may continue receiving Health Education Services. However, Case Management efforts must focus on moving the client into Health Home Care Management. A new service plan must be developed that reflects the ultimate goal of Health Home enrollment, preferably within three to six months. The new service plan must be included with this Quarterly Reassessment.

**GENERAL PROGRESS**

Please describe client's successes and barriers to progress. Describe what the next steps toward achieving viral suppression and self-management are.

\_\_\_\_\_

Reassessment Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor review: \_\_\_\_\_ Date: \_\_\_\_\_

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

Completed by : \_\_\_\_\_ Date: \_\_\_\_\_

### ENGAGEMENT IN HIV CARE

Name:

Agency ID #

Is client currently being seen by a Primary Care Provider for his/her HIV infection?  Yes  No

If **YES**:

How does client rate his/her ability to schedule and keep appointments?

1 2 3 4 5 6 7 8 9 10  
Poorly manages appointments Independently manages appointments

How does client rate his/her adherence to HIV medications?

1 2 3 4 5 6 7 8 9 10  
Missed doses daily Missed doses weekly Never missed doses

Comments:

If **NO**:

What are the main reasons for not being in HIV treatment?

Check all that apply:

- Difficulty with medications
- Finding a Primary Care Physician I feel comfortable with/trust
- Feelings around my diagnosis (depression/sadness, anxiety, shame, etc.)
- Fear/confusion around bloodwork
- Stigma, fear of others knowing my diagnosis (confidentiality)
- Other issues (please list below):

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

If the client is not currently being seen by a PCP, has client been seen in the past by a PCP for his/her HIV infection?

Yes  No

If **YES**:

When was client's last kept appointment?

What are client's reason for leaving treatment?

### UNDERSTANDING HIV/AIDS

PLEASE DISCUSS EACH OF THE FOLLOWING TOPICS  
(COMMENT ON CLIENT'S BASIC LEVEL OF UNDERSTANDING OF EACH)

#### VIRAL SUPPRESSION

#### HIV RELATED KNOWLEDGE/HEALTH LITERACY

#### INTERPRETING LABORATORY RESULTS (BLOOD WORK)

#### COMMUNICATING WITH MEDICAL PROVIDER

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

**CONSEQUENCES OF POOR/SPORADIC MEDICATION ADHERENCE**

**STRATEGIES FOR ADHERING TO MEDICATIONS**

**MANAGING COMORBIDITIES (MENTAL HEALTH DIAGNOSES, DIABETES, SUBSTANCE ABUSE, ETC.)**

**TRANSMISSION AND PREVENTION OF HIV, STI, AND HEP C (RISK REDUCTION)**

**REDUCING THE RISK OF TRANSMITTING HIV TO OTHERS**

**IMPORTANCE OF BASIC NUTRITION**

**GOAL SETTING AND PROBLEM SOLVING**

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

### REDUCING STRESS

### BUILDING SUPPORT NETWORKS

### TREATMENT/CARE READINESS

If client is not in treatment, is client willing to accept a referral to an HIV Primary care provider?  Yes  No

If **YES**:

What kind of support would the client need to help enable him/her to move toward independent coordination of care and self-managed treatment?

If **NO**:

What would help the client to accept and follow through with a referral?

### OTHER DIAGNOSES

Does client have any other non-HIV related diagnoses (mental health diagnoses, diabetes, substance abuse, etc.)?

Please list:

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

Do any of these diagnoses affect client's ability to engage and remain in HIV care and treatment?  Yes  No

Please comment:

### PLAN DEVELOPMENT

Does client feel Health Education can improve his/her ability to independently manage appointments and medications?

Comments:

Does client have any specific concerns or questions about his/her HIV infection? (Please list below)

Has client expressed a desire to learn more about anything related to his/her HIV infection? If yes, please describe:

Health Educator overall comments:

# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

### HEALTH EDUCATION PLAN

Client enrolled in:

Group Education Sessions: \_\_\_\_\_

Individual Education Sessions: \_\_\_\_\_

<b>Health Education Goal #1:</b>	
Target Date:	Outcome:
<b>Health Education Goal #2:</b>	
Target Date:	Outcome:
<b>Health Education Goal #3:</b>	
Target Date:	Outcome:
<b>Health Education Goal #4:</b>	
Target Date:	Outcome:



# AIDS Institute/ Bureau of Community Support Services

## ESS Health Education Screening Form

### CONSENT for SERVICES

HIV/AIDS Health Education Services provided by \_\_\_\_\_ have been fully explained to me. I understand that participation in this program is completely voluntary and I am free to decline services or disenroll at any time. If I decide to end services before completing, I agree to tell the Health Educator my reasons.

I understand that for Health Education Services to be effective, the following activities may be necessary:

1. Intake/screening
2. Participation in individual and/or group health education sessions
3. Successful completion of a set curriculum
4. Taking an active role in Health Education Plan development
5. Case conferencing or communication with my medical provider, case manager, peer support, and other service providers involved with my care

---

Client Signature

Date

---

Staff Signature

Date

## SUGGESTED SERVICE PLAN FORMAT

### SERVICE PLAN

Service Plan Date:

Next Service Plan/Update due:

Goal#: \_\_\_\_\_

PERSON COMPLETING TASK	TASKS TO COMPLETE	TARGET DATE	OUTCOMES	COMPLETION DATE

Goal#: \_\_\_\_\_

PERSON COMPLETING TASK	TASKS TO COMPLETE	TARGET DATE	OUTCOMES	COMPLETION DATE

CM. Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Client Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Supervisor Initial: \_\_\_\_\_ Date: \_\_\_\_\_

## SUGGESTED SERVICE PLAN FORMAT

Goal#: \_\_\_\_\_

PERSON COMPLETING TASK	TASKS TO COMPLETE	TARGET DATE	OUTCOMES	COMPLETION DATE

Goal#: \_\_\_\_\_

PERSON COMPLETING TASK	TASKS TO COMPLETE	TARGET DATE	OUTCOMES	COMPLETION DATE

CM. Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Client Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Supervisor Initial: \_\_\_\_\_ Date: \_\_\_\_\_

