ENDING THE HIV EPIDEMIC(EHE)
Standards of Care Manual

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CUYAHOGA COUNTY
BOARD OF HEALTH
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Introduction

Background—Ending The HIV Epidemic

In the 2019 State of the Union address, a new public health priority for the United States was announced: Ending the HIV Epidemic (EHE). Ending new HIV infections is now possible. Our longstanding HIV prevention mechanisms, such as condom use and syringe service programs, continue to be effective in reducing new transmissions. Furthermore, new prevention methods are increasingly present in communities including the U=U movement and PrEP.

In addition to successful prevention and treatment, new ways to intervene during an HIV outbreak are being utilized to reduce the impact when an outbreak does occur.

Fifty-seven jurisdictions with the highest occurrence of HIV transmissions were targeted for the first round of funding to plan and implement new services aimed at greatly reducing new HIV transmission. Included in these fifty-seven jurisdictions were three in Ohio: Cuyahoga, Franklin, and Hamilton counties.

Cuyahoga County has a long history of investment in HIV services, through both private and public funds preceding the Ryan White Act in 1990. The county, located in the Cleveland-Lorain-Elyria transitional grant area (TGA), is well positioned to leverage existing Ryan White and other public and private resources as well as existing infrastructure to achieve the primary goal set out in the national plan: a 75 percent reduction of new infections between 2017 and 2025 and a 90 percent reduction of new infections by 2030. The Cuyahoga County Board of Health and other committed community partners have been actively engaged in activities to reduce new transmissions through prevention efforts, diagnose those with HIV, link PLWH (persons living with HIV) to care, provide support for PLWH to remain in care, and plan for potential outbreaks. This work will continue under the structure of the Cuyahoga EHE plan.

Ending the HIV Epidemic cannot be achieved by one agency, rather it is a collaborative effort that will require active engagement from community-based agencies and community members. This plan welcomes involvement from the entire community during the five-year implementation. The participation of multiple health and social service agencies, as well as individual advocates during the development of this plan, indicates the community is fully engaged in this process and are likely to remain committed to the goal of reducing new HIV transmissions by 75 percent over the next five years.

In order to make progress on the current goals, CCBH & EHE partners have identified eight overarching strategies that touch all areas of work related to HIV. Additionally, strategies have been developed in each of the four pillars; Prevent, Diagnose, Treat, and Respond.

Currently, EHE Cuyahoga County funds the following services at local agencies:

Prevention

- Routine Opt-Out rapid HIV testing in emergency departments, syringe service providers, and correctional facilities
- Rapid self-test kits distribution
- Safer sex tools and medical supplies distribution
- HIV-specific sex education in schools
- Community outreach efforts
- Risk reduction education at community centers

Care

- Rapid Start ART
- Medical transportation
- Intensive medical case management
- Emergency financial assistance for PWLHA
- Community Health Worker (CHW) certification
- Peer Navigation (CHW) positions with care providers
- Psychosocial education and support services

Background—Standards of Care

The purpose of these service standards is to outline the elements and expectations for all Ending the HIV Epidemic (EHE) care service providers to follow when implementing a specific service category. Service Standards define minimally acceptable levels of quality in service delivery and ensure that uniformity of service exists in the Cuyahoga County jurisdiction, as such that clients/patients of these services categories receive the same quality of service regardless of where or by whom the services are provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all clients/patients and will be used as contract requirements, in program monitoring, and in quality management.

Many of our sub-recipients receive both EHE *and* Ryan White Part A funding. Billing for services within CAREWare may vary depending on the needs of the client/patient and their eligibility for RW Part A. While there are no requirements for EHE eligibility, there are specific requirements for RW Part A, and each service provider should be made aware of when these differences in billing are to be made.

For more information on Ryan White Part A services and Standards of Care, please contact Monica Baker, Ryan White Supervisor, at mbaker@ccbh.net.

Additionally, you can find more information on CAREWare usage and entering subservice categories here: https://www.ccbh.net/wp-content/uploads/2020/05/CAREWare-User-Manual-Cleveland-TGA-May-2020-Final.pdf

Intake Requirements

To establish a care relationship, the client intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of the person completing the intake
3. Client name, address, phone number, date of birth, and CAREWare ID
4. Language(s) spoken and/or preferred language of communication
5. Best communication method(s) to be used for follow-up
6. Demographics (sex at birth, current gender, race/ethnic origin)
7. HIV status, year of diagnosis, and relevant risk factor(s) for HIV infection
8. Client Income documentation (Self-attestation signature for zero-income households)
9. Housing status, and residency documentation
10. Insurance status
11. Emergency Contact(s)
12. Any other service-specific data or data required for the CAREWare system
13. Documentation of financial need.

All agencies are required to have a client intake policy on file. It is the responsibility of the agency to determine and document. Clients must live or receive medical services in Cuyahoga County and have an HIV/AIDS diagnosis. Services will be provided to clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.

Tracking Outcomes

Linked to Care Outcome

Linked to Care can be defined as having one medical visit, CD4 test, or viral load test within the measurement year. All clients receiving services should be linked to care by meeting one of these three care markers, at a minimum.

Prescription of Antiretrovirals (ART) Outcome

All clients should be prescribed antiretroviral medication at the onset of their care. The client's ART prescription should be updated annually, at a minimum, in CAREWare.

Viral Load Outcome

A client's viral suppression is the ultimate goal of providing services. Viral suppression can be defined as <200 copies/ml and will be entered into CAREWare ever six months, at a minimum, from the onset of EHE care for the duration of the project funding.

Personnel Qualifications

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance (including respect for persons, client confidentiality [HIPAA], cultural responsiveness, and cultural humility). Staff must be able to work effectively with their clients, developing supportive relationships, facilitating access to needed services, and assisting clients in achieving their maximum possible level of independence in decision-making and retention in care.

ENDING THE HIV EPIDEMIC (EHE)

Standard of Care: Emergency Financial Assistance

Background

The need for emergency financial assistance is driven by the high levels of poverty among people living with HIV and AIDS. Over time, HIV in the United States has evolved to become an epidemic that is heavily concentrated in working-class and low-income communities. The lower an individual's socioeconomic status, the greater the risk of HIV infection. Poverty diminishes the ability of an HIV-affected household to undertake self-care or access essential health services.[1]

The purpose of this program is to provide direct financial assistance to eligible clients who are severely affected by the HIV epidemic and the economic barriers to care. The goal is to provide optimal HIV care and treatment for people with HIV who are low-income, uninsured, and underserved, to improve their health outcomes. The program is one of last resort—meaning the program can help cover some of the costs associated with living with HIV not otherwise covered by insurance or other community resources.

Service Category Definition

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

It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EHE Care Program funds for these purposes will be the payer of last resort, and for limited amounts, use, and periods of time. Continuous provision of an allowable service to a client should not be funded through EFA.

EFA activities are composed of the following eligible services:

1. Emergency rental assistance (first month's rent, past due rent)
2. Emergency utility payments (gas, electric, and water)
3. Emergency telephone services payments
4. Emergency food vouchers
5. Emergency moving assistance

[1] Pellowski, J., et al., A pandemic of the poor: social disadvantage and the U.S. HIV epidemic. Am Psychol, 2013. 68(4): p. 197-209

6. Emergency medication

Requests for exceptions to this EFA definition must be submitted to the Cuyahoga County Board of Health Ending the HIV Epidemic Care Program.

Key Service Components & Activities

Emergency financial assistance (EFA) provides limited one-time or short-term payments to assist a client with an urgent need for essential items or services necessary to improve health outcomes. These payments are to only occur a limited number of times and for limited periods of time.

EFA payments are short-term and limited in amount. After two instances of client requests for the same type of EFA, clients who are in need of more regularly occurring assistance should be referred to longer-term services such as the AIDS Drug Assistance Program (ADAP), housing assistance, food services, and medical transportation.

Providers are responsible to determine the appropriateness of EFA use and to confirm the urgent need for each EFA request. A client's urgent financial need may arise in a situation that does not allow a sub-recipient to exhaustively search for alternative sources of funding. Subrecipients providing EFA are expected:

- To use their discretion in balancing the best interest of the client and the limited nature of the EHE funding
- To develop procedures to prevent mismanagement of these funds
- To thoroughly document uses of EFA funding
- To thoroughly document when EFA funding was not provided after client request

Unallowable uses of EFA include:

- Direct cash payments to clients, family, or household members
- Case equivalent payments to clients, such as a pre-paid purpose credit card redeemable for cash
- Payment for storage of client belongings
- Pre-Exposure Prophylaxis (PrEP)
- Payments for tobacco, firearms, alcohol, or other drugs taken without support of a licensed medical provider
- Payments that duplicate other EFA requests or assistance from another funded service (such as housing assistance, medical transportation, or food services)
- Payments for other types of needs, such as dental, or medical care, which should be delivered under another service category (for example, oral health or outpatient ambulatory health care)

Subrecipients must train providers, non-service provider staff and volunteers on what costs are allowable under EFA and have a high level of oversight to ensure EFA is not used for unallowable purposes.

Subrecipients must maintain receipts and evidence of payment made using EFA funds to verify that no direct cash payment was provided to the client and that funds were used for allowable costs.

Providers will review the client's EFA request and assess if the client need has been well-described and supported. Providers will plan for the delivery of EFA and will inform clients of the amount of assistance that will be provided, the timeframe in which EFA will be provided, and any restrictions on the EFA.

If EFA is used for a utility payment, temporary housing assistance, medications not covered by ADAP, providers must maintain proof of amount due, such as a utility bill for the month being paid or an invoice or statement from landlord or pharmacist.

Documentation

The client record will document:

- The need and justification for EFA
- Dates when EFA funds were requested and provided
- The purpose of the EFA funds
- The amount of EFA funds given to the client
- The method of providing EFA (i.e. voucher, direct payment to agency, direct payment to landlord, etc.)
- The number of times and amount of time EFA was provided. If the payment is one-time and another payment is not planned, this must be noted
- Any circumstances when EFA was not provided after requested by the client

If vouchers or gift cards are used, there must be a signed receipt for each distribution to the client, and a signed statement wherein the client acknowledges and agrees to the purpose(s) of and restrictions on the card or voucher. The agency is responsible for implementing a mechanism to track all gift cards (vendor/store, card number, amount, etc.) that are purchased or distributed through EFA funding.

Subrecipients must have written policies that distinguish EFA and other service categories, along with policies to prevent misuse of EFA funds.

The client record must contain documentation that the client's EFA request was reviewed, and the client was informed about the amount of assistance provided, the timeframe in which EFA will be provided, and restrictions on EFA. The client record must contain proof of amount due, such as a utility bill for the month being paid or an invoice or statement from the landlord or pharmacist.

Limits of EFA

In addition to the unallowable list above, subrecipients must also monitor and limit financial assistance in the following ways in order to assist as many clients as possible:

- No payment/payment accumulation shall be more than $1,200 in a 12-month period per client
- Requests above this threshold should seek pre-approval from CCBH before the EFA assistance is provided along with a justification for the circumstance

Care and Quality Improvement Outcome Goals

The overall treatment goal of the Emergency Financial Assistance (EFA) program is to provide assistance on a temporary basis to eligible individuals living with HIV/AIDS in the jurisdiction to ensure access to therapies for improved and/or sustained health.

Clinical Quality Improvement outcome goals for EFA include:

- 100% of all files include an assessment of presenting need and qualification for EFA service.
- 80% of EFA clients are linked to medical care as documented by at least one medical visit, viral load or CD4 test reported in the measurement year

Subservices in CAREWare

The following subservices will be used in CAREWare to track EHE activities related to this initiative:

EHE EFA Payment ($XX.00)

[EHE EFA] Prescription

Outcome Standards

No.	Standard	Measure	Goal
1.	Service providers dispensing medications adhere to all local, state, and federal regulations, and maintain current licenses required to operate as a medication dispensary in the State of Ohio (*Clinical sub-recipients only*).	Documentation of current pharmacy license for the State of Ohio is reviewed (*Clinical sub-recipients only*).	100%
2.	Service provider is enrolled in the Federal 340B Drug Pricing	Documentation of current 340B certification is reviewed (*Clinical sub-recipients only*).	100%

	Program (*Clinical sub-recipients only*).		
3.	Client file includes an assessment of presenting problem/need requiring EFA services.	Documentation of eligibility and need evident in the client chart.	100%
4.	Client file includes a description of the date and type of EFA provided.	Documentation of date and description of EFA distributed evident in the client chart.	80%
5.	Drugs distributed under EFA are included on the approved Ohio Drug Assistance Program formulary or the agency has received prior approval through the exception request process with the Grantee (*Clinical sub-recipients only*).	Documentation that distributed drug(s) is/are on the approved formulary or have received prior-approval evident in the client chart (*Clinical sub-recipients only*).	80%
6.	Client did not receive EFA services for longer than 90 days.	Documentation that EFA services were limited to 90 days or less, evident in client chart.	80%
7.	Client is linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year evident in client chart (*can be a client report*).	80%
8.	Client file has documentation supporting payment with EFA services.	Documentation such as most recent utility bill, number of household members, income information (if applicable), state ID, medical information (if applicable), records describing current & housing needs, description of financial need, and receipt of payment.	100%
9.	Client is prescribed ART.	Documentation that client was prescribed ART in the 12-month measurement year as documented by the intensive medical case manager and/or clinician.	80%
10.	Client is virally suppressed.	Documentation that the client has a viral load <200 copies/ml at last test as documented by the intensive medical case manager.	80%

ENDING THE HIV EPIDEMIC (EHE)

Standard of Care: Intensive Medical Case Management

Background

This document serves as guidance for those agencies who are conducting Intensive Behavioral Health Medical Case Management (IMCM) activities under the Ryan White Part A Ending the HIV Epidemic (EHE) Initiative.

This Standard of Care should be interpreted as an expansion of our existing Medical Case Management service category, for the provision of providing Intensive Medical Case Management services for clients that have a high acuity score, high PHQ-9 score, or other immediate mental health or behavioral health concerns as determined through a comprehensive psychosocial assessment. Please refer to the Ryan White – Part A Medical Case Management Standard of Care for further guidance on standard Medical Case Management Services. Clients do not need to be eligible for Part A to receive EHE IMCM services.

Intensive Behavioral Health MCM should be utilized in situations where a client's need requires such care, as determined by the healthcare professional providing services, particularly focused on clients suffering from behavioral, mental health issues, or substance use disorders. Agencies funded for this project will be required to create a protocol to determine usage and eligibility for Intensive Behavioral Health MCM and submit to CCBH on an annual basis.

Service Category Definition

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

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

IMCM services have as their objective of improving behavioral health care outcomes alongside providing collaborative care with psychiatry for clients whose mental health, developmental disability, and/or substance use issues create barriers to achieving viral suppression. Traditional Medical Case Management (MCM) services have as their objective to improve health care outcomes whereas Non-Medical Case Management (NMCM) services have as their objective providing guidance and assistance in improving access to needed services.

Medical Case Managers play a vital role in supporting clients across the continuum of HIV care and ensure full engagement in care and continual movement toward Viral Load suppression. If client needs are appropriately met, the level of case management should decrease with time from *Intensive* to *Moderate* to *Basic* to *Self-Management*. The table below shows the recommended duration for each Level of Case Management. These time frames should be used in conjunction with the Service Plan, and as a guideline for transitioning clients between IMCM to MCM and/or NMCM. In addition, the time frames are designed to minimize the need for case management waiting lists and large caseloads.

Management Level	Recommended Duration at Each Level
Self-Management	Desired level
Basic Management	6 months
Moderate Management	12 months
Intensive Management	18 months

Key Service Components & Activities

Comprehensive Needs Assessment

The Comprehensive Needs Assessment is an information gathering process to identify customer issues and care needs. It is a cooperative and interactive process between a client and Medical Case Manager. The Medical Case Manager collects, analyzes, synthesizes, and prioritizes information which identifies client needs, resources, and strengths for the purposes of developing an Individualizes Care Plan (ICP) to address those needs.

Each client will participate in at least one face-to-face (in-person, video, or telephonic) interview with their assigned Medical Case Manager within ten (10) business days of determining eligibility to complete the Comprehensive Needs Assessment.

Client Assessment is an ongoing process and is used to evaluate progress, identify unresolved and/or emerging needs, guide appropriate revisions in the Individualized Care Plan (ICP), and inform decisions regarding discharge from Intensive Medical Case Management (IMCM) services and/or transition to other appropriate services. Client Assessments must also be conducted in the event of significant changes in the client's life.

Individualized Care Plan

The Individualized Care Plan (ICP) should document long- and short-term goals and objectives to improve the client's healthcare outcomes. It should be reviewed and modified based on the acuity level identified. Within ten (10) business days of determining eligibility, the MCM will develop the Individualized Care Plan and document whether the client was offered/received a copy. In an ongoing interactive process with the client, problems are identified and prioritized. Identified problems are addressed through a planning process that include the mutual development of goals, assigned activities, and reporting outcomes.

The Individualized Care Plan (ICP) should contain the following:

- Prioritized goals and measurable objectives responding to client needs and addressing barriers
- Planning tasks and action steps to be completed to help a client meet their goals with a specified timeframe. The name of the person who will be responsible for the assigned task: either the client, the Medical Case Manager, or both; should be notated.
- Referrals for support services
- Documentation of the client's participation in primary medical care
- Notation of ongoing HIV education/counseling
- Client signature and date, signifying participation with the development and agreement with Plan

Treatment Adherence Counseling

The medical case manager is responsible for the provision of treatment adherence counseling to ensure readiness for or adherence to complex HIV/AIDS regimens. Information about the client's readiness for treatment should be shared with the prescribing physician. Treatment adherence must be incorporated into the Individual Care Plan to support the client with taking all their medications as prescribed, making, and keeping appointments; addressing barriers to care and treatment; and reducing risky behaviors by encouraging therapeutic lifestyle changes, as necessary. The agency must have clear policies and procedures for missed appointment follow-up, especially with clients who are unstably housed, homeless, pregnant, or report no contact information.

Coordination & Monitoring of IMCM Individualized Care Plan (ICP)

There must be at least one documented contact with active clients every 90 days or as dictated by client need. The medical case manager must monitor the Care Plan and document the client's progress on their goals.

The client record should include:

1. Progress notes for each contact
2. Progress notes recording activities on behalf of the client to implement the Care Plan

3. Progress toward Goals
4. Communication with referring agency i.e., if appointments were kept and medications prescribed
5. Maintain contact with client by phone or at face-to-face meetings. Depending on client need
6. Documentation of follow-up for referred services
7. Documentation of follow-up to missed appointments
8. Address emergency situations as they arise
9. Adjustment to Care Plan if necessary
10. Case conferencing when necessary
11. Crisis intervention when necessary

Referrals and Linkages

The medical case manager will refer the client to apply for medical, social, financial, housing, and/or other needed services as specified in the client's Individualized Care Plan.

Formal Reassessment of Needs

A formal re-examination of the client's need for IMCM services should be conducted to identify changes that occurred since the initial or most recent assessment.

The Re-Assessment should include:

1. Individualized Care Plan updates must occur at least every six months
2. Summary of progress in achievement of goals must be documented in client's file
3. Review of client's clinical, financial, and support needs to identify changes and/or additional service needs
4. Multidisciplinary team case conference with other providers, when appropriate
5. Re-assessment for nutritional, mental health, oral health, and substance use disorder issues should be completed annually

Subservices in CAREWare

Intensive Behavioral Health MCM activities funded by EHE will fall into the Medical Case Management service category. The following subservices will be used in CAREWare to track EHE activities related to this initiative:

EHE MCM Behavioral Health

EHE MCM Core Service Coordination

EHE MCM ISP/Client Assessment

EHE MCM Support Service Coordination

Outcome Standards

No.	Standard	Measure	Goal
1.	Client is assessed and determined to be eligible for IMCM (Intensive Medical case management) services.	Evidence of need for IMCM.is documented through assessment score(s) (ex. Acuity, PHQ9, etc.)	80%
2.	Intensive MCM clients have a completed comprehensive individual care plan.	Documentation of completed comprehensive individual care plan is included in the file of all clients receiving services in the measurement year.	80%
3.	Intensive MCM clients are continuously monitored to assess the efficacy of their individual care plan.	Documentation of case management meeting and/or attempted client contact occurred at least monthly. Client assessment and progress notes are documented in the client chart as evidence.	80%
4.	Intensive MCM Clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year as documented by the intensive medical case manager.	80%
5.	Intensive MCM Clients are prescribed ART.	Documentation that client was prescribed ART in the 12-month measurement year as documented by the intensive medical case manager.	80%
6.	Intensive MCM Clients are virally suppressed.	Documentation that the client has a viral load <200 copies/ml at last test as documented by the intensive medical case manager.	80%
7.	Client is successfully transitioned from IMCM to MCM/Non-MCM as needed.	Documentation that the goals of the individual care plan have been satisfied and IMCM is no longer needed.	80%

Intensive MCM clients' viral load data is required to be tracked and entered into CAREWare from the onset of EHE Care through the duration of the EHE 5-year project period.

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Standard of Care: Medical Transportation

Background

The purpose of service standards is to outline the elements and expectations of EHE Care service providers when implementing a specific service category. Service Standards define the minimally acceptable levels of quality in service delivery and ensure that uniformity of service exists such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and quality management.

Service Category Definition

The goal of Medical Transportation is to provide non-emergency transportation services to eligible clients receiving care in Cuyahoga County that enables them to access or be retained in core medical and support services.

Medical transportation may be provided through:

- Mileage reimbursement (through a non-cash system) that enables customers to travel to needed medical or other support services, but should not, in any case, exceed the established rates for federal programs (i.e. gas gift card)
- HIPAA-compliant rideshare, voucher, or token systems

Subrecipient shall not bill the EHE program for the following unallowable costs:

- Direct cash payments or cash reimbursements to customers
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Subservices in CAREWare

Medical transportation services activities funded by EHE will fall into the support service category. The following subservice will be used in CAREWare to track EHE activities related to this initiative:

EHE MT Ride Share

Outcome Standards

No.	Standard	Measure	Goal
1.	Subrecipient shall conduct an initial transportation assessment for all persons receiving transportation services.	Agency medical transportation policy on file	100%
2.	Subrecipient shall determine whether the client has known upcoming health care appointments for which there is no other source of transportation.	Client appointment verification record or documented medical appointment.	100%
3.	Documentation of transportation service in client's record signed and dated by client and agency staff	Agency mileage/voucher/token logs Agency rideshare account on file Documentation of transportation service in client's record signed and dated by client and agency staff CW data entry reflecting provision of medical transportation service	100%
4.	Clients receiving medical transportation services are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year.	80%
5.	Medical transportation clients are prescribed ART.	Documentation that client was prescribed ART in the measurement year.	80%
6.	Clients receiving medical transportation services are virally suppressed. (Not applicable if client is newly diagnosed within 6 months of the grant year end.)	Documentation that the client has a viral load <200 copies/mL after 6 months of care.	80%

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Standard of Care: Outpatient & Ambulatory Health Services - Rapid Start

Background

The purpose of service standards is to outline the elements and expectations of EHE Care service providers when implementing a specific service category. Service Standards define the minimally acceptable levels of quality in service delivery to ensure that uniformity of service exists such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and quality management.

Service Category Definition

The rapid start of ART project allows agencies to build capacity to ensure newly diagnosed or new-to-care clients can be given antiretroviral medication at their first appointment or interaction with the medical provider. The capacity building will allow medical providers to cut down barriers that may prevent ART prescription upon first appointment or interaction so that a client may immediately begin their path towards viral suppression. Clients do not need to be eligible for Part A to receive EHE Rapid Start services. Rapid Start ART clients' viral load data is required to be tracked and entered into CAREWare from the onset of EHE care through the duration of the EHE project period.

Key Activities:

- Develop a referral system that will connect clients to care within 24 hours of notification from community partners
- Mobilize a multidisciplinary team to see a client on a same-day basis, if possible
- Ensure follow-up care
- Engage patients through high-intensity support

Subservices in CAREWare

Rapid Start ART services funded by EHE will fall into the Outpatient Ambulatory Health Services service category. The following subservices will be used in CAREWare to track EHE activities related to this initiative:

EHE OAHS Rapid Start Labs
EHE OAHS Rapid Start Physician Visit

EHE OAHS Rapid ART Service Coordination
EHE EFA Rapid Start Medication

Outcome Standards

No.	Standard	Measure	Goal
1.	Care is provided by health care professionals certified in Ohio to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van	Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.	100%
2.	Clients receiving Rapid Start services are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within the measurement year.	80%
3.	Clients receiving Rapid Start services are prescribed ART at first appointments or interaction with provider.	Documentation that client was prescribed ART at the onset of care; within 30 days of diagnosis.	80%
4.	Clients receiving Rapid Start services are virally suppressed. (Not applicable if client is newly diagnosed within 6 months of the measurement year end.)	Documentation that the client has a viral load <200 copies/mL after 6 months of care.	80%
5.	A treatment plan is established that is appropriate to each client's age, gender, and specific needs, and that both provider and client have reviewed. Plans include, at a minimum: • Diagnostic information; • Referrals (as appropriate) • Discussion of risk reduction, HIV education, secondary prevention, and behavior modification (as appropriate) • Medications (including a current list of prescribed medication or notations explaining the absence of prescriptions)	Applicable documentation in service records or electronic medical record of a treatment plan.	80%

	• Education related to treatment adherence and the management of side effects (as appropriate).		
6.	Clients receiving Rapid Start services are provided follow-up by a peer navigator, social worker or medical provider within 90 days of initial linkage to care appointment.	Documentation of contact made, contact attempt(s), follow-up medical visit, viral load, and/or CD4 test 90 days post diagnosis.	80%
7.	Clients receiving Rapid Start services are provided follow up by a peer navigator, social worker or medical provider within 180 days of initial linkage to care.	Documentation of contact made, contact attempt(s), follow-up medical visit, viral load, and/or CD4 test 180 days post-diagnosis.	80%
8.	Staff follow-up with clients who miss medical visits to address barriers and reschedule the Appointment.	Documentation of contact made, contact attempt(s), or follow-up medical visit in service records.	80%

Licensing

All medical providers (MD, DO, RN, NP) providing OAHS Rapid Start services must hold a valid license to practice medicine in the state of Ohio.

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Standard of Care: Credentialed Peer Navigators (Community Health Workers)

Background

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/intermediary between health/social services and community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individuals and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.[2]

May be also known as: *Peer Navigator, Peer Educator, Linkage Care Coordinator, Patient Navigator, Health System Navigator, Outreach Worker, Counselor, or "Promotora."*

A CHW can enhance the HIV Care team by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people with HIV. The CHW role across the HIV care continuum may include:

- Assisting, educating, and supporting people with HIV to become aware of their status
- Linking and engaging people with HIV into medical care
- Helping people with HIV adhere to treatment
- Explaining health benefits and other types of available assistance to people with HIV

Service Category Definition

Peer Navigators and Community Health Workers (CHW) serve as a liaison/link/intermediary between health/ social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW can enhance the HIV care team by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people with HIV. EHE Peer Navigation clients' viral load data is required to be tracked and entered into CAREWare from the onset of EHE care through the duration of the EHE 5-year project period.

Key Activities:

- Assisting, educating, and supporting people with HIV to become aware of their status;
- Linking and engaging people with HIV into medical care;

[2] https://www.apha.org/apha-communities/member-sections/community-health-workers

- Helping people with HIV adhere to treatment; and
- Explaining health benefits and other types of available assistance to people with HIV.

Key Service Components and Activities

- CHW will work with a social worker to identify clients that would most benefit from peer navigation services (ex. non-virally suppressed; newly diagnosed). CHW also works with the care team to identify specific activities to assist the client
- Contact the client to check in regularly about the progress of getting needs met, referrals, and obtaining care
- Conduct regular education sessions with clients
- Document daily activities on an encounter form and/or in the electronic health record
- To maintain communication with the care team, suggested items to document in the electronic health record include:
    - Attempted contacts for follow-up appointments
    - Referrals made and completed for other medical care or support services (such as mental health care, and substance use treatment)
    - Notes about client reported or circumstances that could impact health care or taking medications (i.e. client reported losing their job and staying with parents, client reported mother passed away and missed medications, etc.)

Service Delivery Model

Develop a plan for CHW outreach and recruitment of PLWHA, including the specific priority populations to be served by CHWs. Examples include:

- People who are not virally suppressed or newly diagnosed
- People who have missed two or more appointments or have had only one medical appointment in the past six months (unless indicated by the health care provider)
- People experiencing homelessness/unable housing situations
- People with substance and/or mental health disorders
- People recently released from jail/prison

Strategies to identify and recruit new clients, and re-engage existing clients who may have fallen out of care:

- Review program's data to identify clients who have fallen out of care. In defining "out-of-care," prioritize clients who have not had a lab or medical visit at the clinic in at least six months, or clients who are not virally suppressed (possible sources: D2C lists, CAREWare, EMR)
- Review clinic testing data to identify eligible people who are newly diagnosed or who never linked to care

- Have the CHW meet with case managers and health care providers to identify clients from their caseloads who also may benefit from CHW support
- Review appointment data to identify clients who have missed two or more appointments
- Set up an internal and external referral & tracking systems to document the identification and recruitment process

Subservices in CAREWare

Peer Navigation activities funded by EHE will fall into the Early Intervention Services (EIS) services category. The following subservices will be used in CAREWare to track EHE CHW activities:

EHE EIS CHW Linked to Care

This subservice category will be used to indicate any peer navigation activity where a linkage to care was made. This includes time spent on helping individual make an appointment and also any time spent verifying that this individual attended the appointment.

EHE EIS CHW Service Coordination

This subservice category will be used for time spent on any other remaining peer navigation activities. This can include time spent on phone calls/voicemails, checking EMRs, data entry, etc.

Please note the following: *1 Client Encounter of 15 minutes = 1 Unit*.
Client encounter can include phone calls, emails, and time spent on EMR research on a patient.

Outcome Standards

No.	Standard	Measure	Goal
1.	Peer Navigation clients are linked to medical care.	Documentation that the client had at least one medical visit, viral load, or CD4 test within 90 days of first EIS visit/service.	80%
2.	Peer Navigation clients are prescribed ART.	Documentation that client was prescribed ART in the measurement year.	80%
3.	Peer Navigation clients are virally suppressed.	Documentation that the client has a viral load <200 copies/ml at last test.	80%
4.	Electronic health record entries related to communication, communication attempts, and referrals	Documentation of at least one EHR communication attempt and/or referral made by CHW/peer navigator.	80%

EHE Peer Navigation clients' viral load data is required to be tracked and entered into CAREWare from the onset of EHE Care through the duration of the EHE 5-year project period.

Monitoring, Support, & Supervision

Agencies should provide administrative and clinical supervision using a "strengths-based approach" to CHWs on a consistent schedule. Supervision is critical for ensuring the integration of the CHW into the care team and CHW success. Recommendations and considerations include:

- CHW attends team meetings where the HIV care team communicates in person, via telephone, or the electronic health record to discuss cases, identify new clients for follow-up, and document progress of existing clients
- CHW meets weekly with administrative supervisor, to debrief weekly activities, and to discuss activities for the next week; this is a time to troubleshoot challenges related to clients or staff
- CHW participates in clinical supervision at least once per month
- CHW establishes a transition or close-out plan for clients who are ready for less intensive services, who become inactive, or hard to reach after repeated attempts
- Ensure CHW Safety – Create protocols that support safety in the field. Develop a formal process to debrief situation that supports CHWs and other clinic staff following disturbing, difficult events. Consider cross-agency peer support networks for CHWs
- Support CHW Professional Growth – Connect and encourage CHWs to be active members of local and state organizations for workforce development, HIV planning, and other advisory groups that can support their work and address the needs of clients

To help CHWs get started, the following activities should take place:

- *Provide Resources Lists* – Provide contact lists of partner agencies for assisting clients with identifying and accessing resources in the community
- *Set-Up Care Team Meetings* – Set-up meetings with the care team who will be interacting with the CHWs on a daily basis
- *Provide Systems Access and Resources* – Schedule time IT and Human Resources to get passwords and orientation to data systems, benefits information, building access, an ID badge, and resources
- *Orient CHWs* – Schedule specific orientation, such as new employee orientation, Health Insurance Portability and Accountability Act (HIPAA) training, human subjects research training, cultural competency training, and other basic content necessary for the job. Remember to highlight confidentiality and documentation expectations related to Substance Abuse and Mental Health
- *Identify Documentation Requirements* – Provide detailed training on documentation expectations, requirements, and processes
- *Share Organizational Policies* – Provide copies of agency and department policies, such as home visiting policies, use of cars, transporting clients, privacy and confidentiality, use of

cellphone, and safety protocols. Include examples of client and staff interactions that need the immediate attention of the supervisor

- *Keep CHWs Informed* – Provide information about specific organization days, such as retreats, all-day staff meetings, and special events that the CHW is expected or invited to attend
- *Trainings* – Including Foundational Knowledge about HIV and CHW Core Competencies. Offer or connect a CHW with an initial 40-hour certification training course
- *Update and Distribute Revised Workflows* – The integration of CHWs into the care team will result in changes to some workflows. Revise workflows to include the CHW roles and responsibilities. Distribute updated workflows to all staff and review in staff meetings. How the agency handles internal and external referrals to CHWs needs to be clearly articulated, as does the process for client referrals to outside agencies/resources

ENDING THE HIV EPIDEMIC(EHE)

Standard of Care: Psychosocial Support Services

Background

The purpose of these service standards is to outline the elements and expectations all EHE Care service providers are to follow when implementing a specific service category. Service Standards define the minimally acceptable levels of quality in service delivery and ensure that uniformity of service exists such that clients of this service category receive the same quality of service regardless of where or by whom the service is provided. Service Standards are essential in defining and ensuring that consistent quality care is offered to all customers and will be used as contract requirements, in program monitoring, and in quality management.

Service Category Definition

Psychosocial Support Services provides individual and/or group support and counseling services to address clients' continuing behavioral and physical health concerns. Psychosocial support should be delivered by staff, volunteers, and/or peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve the quality of life for participants.

Key activities include:

- Support and counseling activities
- HIV support groups
- Pastoral care/counseling services
- Caregiver support

Exclusions:
Funds under this service category may not be used for social/recreational activities or to pay for a client's gym membership.

Subservices in CAREWare

Psychosocial Support services funded by EHE will fall into the support service category. The following subservices will be used in CAREWare to track EHE activities related to this initiative:

EHE MCM Psychosocial Support services

Outcome Standards

No.	Standard	Measure	Goal
1.	Psychosocial Support services are provided by qualified professionals or peers.	Documentation that staff have basic knowledge of HIV/AIDS and/or infectious disease and are able to work with vulnerable subpopulations as documented through staff personnel records.	100%
2.	Documentation is maintained of all topics discussed through support groups with correlating sign-in sheets	Documentation of agendas/notes, and sign-in sheets reviewed.	80%
3.	Access and engagement in primary care topics were discussed with the client at least once in a 3 month period	Documentation of agendas/notes, and sign-in sheets reviewed.	80%
4.	Access and engagement in medical case management were discussed with the client at least once in a six month period.	Documentation of agendas/notes, and sign-in sheets reviewed	80%
5.	Psychosocial client is linked to medical care	Documentation that client had at least one medical visit, viral load, or CD4 test within the measurement year evident in the client chart. (can be client report).	80%
6.	Psychosocial client clients are prescribed ART.	Documentation that client was prescribed ART in the measurement year (can be client report).	80%
7.	Psychosocial client is virally suppressed. (Not applicable if client is newly diagnosed within 6 months of the grant year end.)	Documentation that client had less than 200 copies/mL at last HIV Viral Load test during the measurement year (can be client report).	80%