

ENDING THE HIV EPIDEMIC (EHE)
Standards of Care Manual
Grant Year - 2026



Cuyahoga County Board of Health
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CCBH CUYAHOGA COUNTY
BOARD OF HEALTH
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ENDING THE HIV EPIDEMIC (EHE) Standards of Care Manual

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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 PWH (persons with HIV) to care, provide support for PWH 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 ten-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 90 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, activities have been developed in each of the five strategies: Prevent, Diagnose, Treat, Respond, and Community Engagement.

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 distribution
- HIV-specific education
- Community outreach efforts

Care

- (EIS) Peer Navigation
- Intensive Medical Care Management
- Medical Transportation
- (OAHS) Rapid Start ART
- Emergency Financial Assistance
- Psychosocial Support Services
- Non-Medical Case Management Services
- (Other Professional Services) Legal Services
- (OAHS) Mobile Health Clinics

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 outside of an HIV positive diagnosis, 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 Anastassia Idov, Ryan White Supervisor, at aidov@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>

Eligibility Criteria

Unlike Ryan White Part A, the EHE Program does not have a limiting eligibility policy. Ryan White Part A eligibility assessments are encouraged by providers receiving both funding streams to prevent duplicating services and resources. EHE Program funds and services are intended to be utilized within the Cuyahoga County jurisdiction. However, these funds can be used outside the jurisdiction to serve those in need within the Cleveland TGA with prior approval from the Board. The EHE Program operates as a payor of last resort. This means that federal funds can only pay for care and medications if no other source (such as Medicaid, Medicare, private insurance, or state programs) is able to pay. Providers must check and exhaust all other options first. Clients receiving EHE-funded services must only meet the following:

HIV/AIDS diagnosis- The patient or client must have a confirmed HIV diagnosis.

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 should 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, identity, expression, marital or parental status, sexual orientation, religion, physical or mental handicap, nationality, 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 Antiretroviral (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 every 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.

Standard of Care: UNIVERSAL STANDARDS

Background

The Universal Standards are the minimum requirements that subrecipients (providers) are expected to meet when providing HIV care and support services funded by EHE. Recipients evaluate subrecipients compliance with the Universal Standards with the measure listed below, during annual site visits, and required reporting. Subrecipients are encouraged to exceed these standards. The Universal Standards ensure that agencies best meet the needs of their clients and are client-focused in the design and implementation of services. The Universal Standards apply equally to services provided in-person and via telehealth.

Key Service Components & Activities

The objective of the Universal Service Standards is to help achieve the goals of each service type by ensuring that programs:

- Have policies and procedures in place to protect clients' rights and ensure quality of care for both in-person and telehealth services;
- Provide clients with access to the highest quality services through experienced, trained, and when appropriate, licensed staff;
- Provide services that are culturally and linguistically appropriate;
- Meet federal and state requirements regarding safety, sanitation, access, public health, and infection control;
- Guarantee client confidentiality, protect client autonomy, and ensure a fair process of grievance review and advocacy;
- Comprehensively inform clients of services, establish client eligibility, and collect and store client information through an established process;
- Effectively assess client needs and encourage informed and active client participation;
- Address client needs effectively through coordination of care when appropriate subrecipients and referrals to needed services;
- Are accessible to all people with HIV in the EHE jurisdiction.

Universal Standards

No.	Standard	Measure	Goal
1.	Structured and ongoing efforts to obtain input from clients in the design and delivery of services.	Documentation of client feedback attached to the sub-recipient's service delivery program.	80%
2.	Provision of services regardless of an individual's ability to pay for the service.	Documentation ensures that provider billing and collection policies do not: deny services for non-payment, deny service	80%

		for inability to produce income documentation, require full payment prior to service, include any other procedure that denies services for non-payment.	
3.	Provision of services without discrimination on the basis of HIV infection, race, creed, age, sex, identity, expression, marital or parental status, sexual orientation, religion, physical or mental handicap, nationality, or any other basis prohibited by law.	Documentation to show that provider delivers services and upholds policies free from discriminatory practices on the basis of HIV infection, race, creed, age, sex, identity, expression, marital or parental status, sexual orientation, religion, physical or mental handicap, nationality, or any other basis prohibited by law.	80%
4.	Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program.	Documentation of updated job descriptions provided to each EHE-funded position.	80%
5.	Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance.	Documentation of staff trainings on the topics of respect for persons, client confidentiality (HIPAA), cultural responsiveness, and/or cultural humility.	80%
6.	All agencies are required to provide clients with access to submit grievances over provider services.	Grievance policy in client file during the measurement year.	100%
7.	All agencies must adhere to eligibility requirements of the EHE jurisdiction.	Documentation of clients proof of HIV/AIDS diagnosis - required only once.	80%
8.	All agencies are required to have a client intake policy.	Documentation of client intake policy on file.	100%
9.	The sub-recipient is required to maintain an individual record for each client served containing service details and all fields required by the RSR.	Documentation of client files with collection of service details and intake demographics specified in current Standards of Care.	80%
10.	Prohibition of employees (as individuals or entities), from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Documentation required by Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services.	100%
11.	Submission of standard reports as well as program-specific reports as outlined in contract.	Records that contain and adequately identify the source of info pertaining to: client level data; aggregate data on services provided, clients served, client demographics, and selected financial information.	80%
12.	Submission of financial reports as outlined in contract.	Records that contain and adequately identify the source of info pertaining to: expenses, obligations, unobligated balances, assets, outlays, program income, interest, and selected financial information	80%

13.	Submission of logged distributions and purchases of gift cards, gas cards, or travel expenses as outlined in contract.	Records that contain gift cards distribution details, gift card purchase details, and/or travel expenses.	80%
14.	Monitoring activities expected to include annual site visits of all providers/subgrantees.	Reviewing of the following program monitoring documents and actions: policies and procedures, tools, protocols, or methodologies, reports, corrective site action plans, progress on meeting goals of corrective action plans.	100%
15.	Performance of fiscal monitoring activities to ensure that EHE funding being used for approved purposes.	Review of the following fiscal monitoring documents and actions: fiscal monitoring policy and procedures, fiscal monitoring tool or protocol, fiscal monitoring reports, fiscal monitoring corrective action plans, compliance with goals of corrective action plans.	100%
16.	Corrective actions taken when provider outcomes do not meet program objectives and grantee expectations.	Review corrective action plans, review resolution of issues identified in corrective action plan, policies that describe actions to be taken when issues are not resolved in a timely manner.	100%
17.	Maintain system for tracking referrals and linkages to care.	Documentation or evidence that provider is tracking referrals and linkages to care.	80%
18.	Inform clients of various HIV services and resources throughout the EHE jurisdiction and/or Cleveland TGA.	Documentation or evidence that provider is informing clients of HIV services and resources.	80%
19.	Demonstrate cultural and linguistic competency in care and services provided to clients.	Documentation of policies and procedures to provide clients with care and services that are equitable, understandable, respectful, responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	80%
20.	Policies and procedures to discharge, transition, and/or close cases when a client: - Relocates out of the service area - Has no direct program contact in the past 18 months despite provider contact to engage in care - No longer needs the service - Discontinues from the services - Is incarcerated for a year or longer - Exhibits threatening behavior that prevents the provision of a service or that prohibits another client from receiving services - Has passed away	Record of discharge, transition, and/or case closure with the client file. Written policies and procedures about discharge process on file at the agency. Record of at least 3 attempts to contact clients before discharge and to communicate about case closures.	80%

	Policies and procedures for discharge must include at least three (3) attempts to contact the client before discharge. The agency must inform client of discharge with information about how they can access services in the future if needed.		
21.	Providers will develop and implement policies and procedures to support retention of clients in care and re-engagement if they fall out of care. These should include staff protocols to follow-up with clients to determine and mitigate barriers to accessing services and continuity of care. Service delivery models that are medium to large group interventions must assess participation.	Written policies on file at the provider's agency. Record of at least 3 attempts to re-engage clients that fall out of care. Record of reason for individual falling out of care (<i>if known</i>).	80%
22.	Agency must have a safety policy/protocol that: • Ensures services are provided in facilities/spaces that are clean, comfortable, and free from hazards • Includes language that protects staff and clients from bullying, discrimination, and sexual harassment • Ensures the safety of staff and clients during community and home-visits • Ensures a place where staff can report incidents.	Documentation of a safety policy/procedure on file at the agency location.	100%

EHE Standard of Care: Credentialed Peer Navigator (Community Health Worker)

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.¹

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, and 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 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;
- Helping people with HIV adhere to treatment; and

¹ <https://www.apha.org/apha-communities/member-sections/community-health-workers>

- 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 PWHA, 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

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

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, text messages, 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 Navigator clients are prescribed ART (<i>or have notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client was prescribed ART in the measurement year.	80%
3.	Peer Navigator clients are virally suppressed, have a lowered viral count after ART start, or have a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that the client has a viral load <200 copies/ml at last test.	80%

EHE Standard of Care: Food Bank/Home Delivered Meals

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 Food Bank/Home-Delivered Meals (FB/HDM) is to provide nutritionally appropriate meals or groceries to persons with HIV who are nutritionally compromised in order to improve health outcomes and support the ability of these clients to remain in their homes and in medical care.

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

- Personal hygiene products
- Household cleaning supplies

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

Key Service Components & Activities

The needs and status of each client receiving Food Bank/Home-Delivered Meals will be monitored. All meals are free-of-charge to the client. All clients must be screened to determine their level of need.

Comprehensive Needs Assessment

The Comprehensive Needs Assessment is an information-gathering process to identify client issues and care needs. It is a cooperative and interactive process between a client and Medical Case Manager and/or Community Health Worker. The Medical Case Manager or Community Health Worker collects, analyzes, synthesizes, and prioritizes information which identifies client

needs, resources, and strengths for the purposes of developing an Individualized Service Plan (ISP) 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 or Community Health Worker within ten (10) business days of determining need.

Client Assessment is an ongoing process and is used to evaluate progress, identify unresolved and/or emerging needs, guide appropriate revisions in the service plan, and inform decisions for transition to other appropriate services. Client Assessments must also be conducted in the event of significant changes in the client's life.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous monitoring to assess the efficacy of the service plan
- Re-evaluation of the service 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
- Client-specific advocacy and/or review of utilization of services

Coordination & Monitoring of Individualized Service Plan

There must be at least one documented contact with active clients every 90 days or as dictated by agency and client need. The medical case manager and/or community health worker must monitor the Service 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 Service 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 meeting—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 Service Plan if necessary
10. Case conferencing with case manager or licensed social worker, when necessary

11. Crisis intervention when necessary

Referrals and Linkages

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

Subservices in CAREWare

Food Bank/Home-Delivered Meals activities 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 HOME DELIVERED MEALS-HOT
EHE HOME DELIVERED MEALS-FROZEN
EHE FOOD BANK-PERSONAL HYGIENE PRODUCTS
EHE FOOD BANK-HOUSEHOLD CLEANING SUPPLIES
EHE FOOD BANK-FOOD ITEMS
EHE FOOD BANK-FOOD VOUCHER PROGRAM

Please note the following: *1 Meal = 1 Unit.*

Service Standards

No.	Standard	Measure	Goal
1.	Food Bank/Home-Delivered Meal services are provided by agencies that maintain appropriate required licensure.	Documentation of appropriate food licensure or licensure required for food delivery personnel reviewed. *For clarification, please see Personnel Qualifications section below.	100%
2.	Agencies providing Food Bank/Home-Delivered Meals collect and maintain signed receipts for all resources distributed.	Documentation of a signed receipt for all services received is maintained and available for review.	100%
3.	Clients received home delivered meals have documented necessity of need updated at least annually.	Documentation of home delivery as a necessity is evident in the client chart.	100%
4.	Clients receiving home delivered meals have individualized service plan updated at least annually.	Documentation of home delivery individualized service plan is evident in the client chart.	80%
5.	Clients receiving home delivered meals have been given referral of benefit services (i.e. SNAP) and transferred to outside service providers.	Documentation that clients are referred to other nutrition-based services following assessment within service plan.	80%

Outcome Standards

No.	Standard	Measure	Goal
1.	Clients receiving Food Bank/Home-Delivered 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%
2.	Clients receiving Food Bank/Home-Delivered Meals are prescribed ART.	Documentation that client was prescribed ART in the measurement year.	80%
3.	Clients receiving Food Bank/Home-Delivered Meals are virally suppressed (<i>Not applicable if client is newly diagnosed within the last 6 months of the grant year</i>).	Documentation that the client has a viral load <200 copies m/L after 6 months of care.	80%

Personnel Qualifications

Any agency providing services in the Food Bank/Home-Delivered Meals (FB/HDM) category must comply with federal, state, and local regulations regarding the provision of food bank services, food item delivery, and/or home-delivered meals including any required licensure and/or certifications to operate the particular food service program involved.

All personnel being billed for delivering meals and/or any food item must hold a valid Ohio driver's license and automobile insurance consistent with state minimum requirements. This also applies to delivery personnel who agencies may have customized their FB/HDM programs as detailed in their proposal to the Recipient.

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.

<u>Management Level</u>	<u>Recommended Duration at Each Level</u>
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 Individualized 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

Service 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%

Outcome Standards

No.	Standard	Measure	Goal
1.	Client is prescribed ART (<i>or has notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client was prescribed ART in the 12-month measurement year as documented by the intensive medical case manager.	80%
2.	Client is virally suppressed, has a lowering viral count after ART start, or has a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that the client has a viral load <200 copies/ml at last test as documented by the intensive medical case manager.	80%
3.	Client is successfully transitioned from IMCM to MCM/Non-MCM as needed, or documentation of assessment that client needs IMCM for another year.	Documentation that the goals of the individual care plan have been satisfied and IMCM is no longer needed.	80%

EHE 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:

- HIPAA-compliant rideshare (i.e. Uber or Lyft) that enables clients to travel to needed medical or other support services, but should not, in any case, exceed the established rates for federal programs

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
- Mileage reimbursement, parking reimbursement, bus passes, vouchers, gift cards or token systems.

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

Service 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. Documentation of patient receiving medical transportation policy at first use, then annually (if needed).	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.	Agency rideshare account on file CW data entry reflecting provision of medical transportation service	100%

Outcome Standards

No.	Standard	Measure	Goal
1.	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%
2.	Medical transportation clients are prescribed ART.	Documentation that client was prescribed ART in the measurement year.	80%
3.	Clients receiving medical transportation services are virally suppressed (<i>Not applicable if client is newly diagnosed within the last 6 months of the grant year</i>).	Documentation that the client has a viral load <200 copies m/L after 6 months of care.	80%

EHE 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

Key Components & Activities

Documentation of labs within 30 days of diagnosis is required by the CDC to be considered successfully linked to care. Typically, a physician will collect the following baseline lab tests: (1) HIV RNA (confirming testing diagnosis and assessing HIV-1 or -2), (2) CD4 levels, and (3) other STI tests, such as syphilis and MPox. These baseline labs are also used for comparison to track whether ART is reducing viral load counts to undetectable levels and to track that CD4 levels are high enough for healthy immune response.

In addition to laboratory tests, patients should receive diagnostic information; education on HIV, risk reduction, U=U, HIV criminalization, ART treatment adherence, and side effects; and referrals for additional services.

The HIV Care Team

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. In addition to physicians and nurses, the HIV care team can benefit from hiring or collaborating with early intervention service associates, Peer Navigators, and case managers.

Early intervention services (EIS) staff and Peer Navigators play a crucial role in the rapid start process. These are the first professionals contacted by HIV testers and DIS when there is a new HIV positive client, as well as the first professionals to interact with the patient after successful linkage. EIS and Peer Navigators make space for a client to be seen by the provider as soon as possible. They assist with medical and nonmedical support throughout the first visit, and often schedule the client's 90-day (3 month) check-up and 180-day (6 month) check-up appointments.

Case management can be introduced to the client during their rapid start visit, particularly if there are concerns about retention in care. Some providers prefer to introduce case management at the 90-day appointment, due to the length and complexity of the rapid start visit. Medical and nonmedical case management can improve behavioral health and social support needs, thus reducing barriers to care and maintaining optimal outcomes.

Successful rapid start programs typically give space on the provider's schedule for same-day appointments. This allows for other clients who are retained in care to not have their visits affected by an impromptu schedule change. It also ensures clients will remain in care when they do not have reschedule an appointment time.

90-day (3 month) and 180-day (6 month) visits are typically scheduled with the client by EIS staff. The purpose of these visits are to confirm that treatment is correctly reducing viral loads, increasing CD4 cells, and any side effects are manageable. If not, the client can discuss other options with the physician. Medical and nonmedical case management should be in coordination with the medical visits to ensure the patient is barrier-free and utilizing support systems. Physicians may move to annual visits in the second year of care depending on the client's circumstances.

Coordination of Medical & Nonmedical Support

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 harmful 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.

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

Service 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.	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 (<i>as appropriate</i>) • Discussion of risk reduction, HIV education, secondary prevention, and behavior modification (<i>as appropriate</i>) • Medications (<i>including a current list of prescribed medication or notations explaining the absence of prescriptions</i>) • Education related to treatment adherence and the management of side effects (<i>as appropriate</i>).	Applicable documentation in service records or electronic medical record of a treatment plan.	80%
3.	Clients receiving Rapid Start services are provided follow-up by a peer navigator, social worker, or medical	Documentation of contact made, contact attempt(s), follow-up medical	80%

	provider within 90 days of initial linkage to care appointment.	visit, viral load, and/or CD4 test 90 days post diagnosis.	
4.	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%
5.	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%

Outcome Standards

No.	Standard	Measure	Goal
1.	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%
2.	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 7-30 days of diagnosis.	80%
3.	Clients receiving Rapid Start services are lowering their viral count during first 6 months of care (<i>Not applicable if client is newly diagnosed within the last 6 months of the measurement year</i>).	Documentation that the client has a viral load <200 copies/mL after 6 months of care.	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.

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.²

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), emergency transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA allowable cost needed to improve health outcomes (with prior approval through an exception form). 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

² 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 (HIV/AIDS medications only)

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

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 three 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. Request for use of EFA that extend beyond two months will require an exception form to be completed and submitted to CCBH (*see Appendix A*).

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 EFA 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
- Cash equivalent payments to clients, such as a pre-paid purpose credit card redeemable for cash
- Payment for storage of client belongings, mortgage payments, or housing repairs
- 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 medical transportation)
- **Rental, utility, and moving assistance outside Cuyahoga County**

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.

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.

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. Receipts and justification for EFA should accompany all fiscal invoices submitted to CCBH.

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 (*see Appendix B*). 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 (*see Appendix C*).

Subrecipients must have written policies that ensures compliance to the EFA SOC and include 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 \$2,500 or three instances (whichever occurs first) in a 12-month period per client.
- Requests above this threshold should seek an exception request (*see Appendix A*) from CCBH before the EFA assistance is provided along with a justification for the circumstance.
- Two or more clients from the same residence may receive the maximum amount each, as long as it is not duplicating the same expense.
- Client must be actively enrolled in non-medical case management services at respective agency to be eligible for EFA housing/utility services (unless approved by the Board).

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

Service 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	Documentation of current pharmacy license for the State of Ohio is reviewed (<i>Clinical sub-recipients only</i>).	100%

	dispensary in the State of Ohio (<i>Clinical sub-recipients only</i>).		
2.	Service provider is enrolled in the Federal 340B Drug Pricing Program (<i>Clinical sub-recipients only</i>).	Documentation of current 340B certification is reviewed (<i>Clinical sub-recipients only</i>).	100%
3.	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 (<i>Clinical sub-recipients only</i>).	Documentation that distributed drug(s) is/are on the approved formulary or have received prior-approval evident in the client chart (<i>Clinical sub-recipients only</i>).	80%
4.	Client file includes an assessment of presenting problem/need requiring EFA services.	Documentation of eligibility and need evident in the client chart.	80%
5.	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%
6.	Client did not receive EFA services more than three times for a persistent or ongoing issue.	Documentation that EFA services were limited to three times for a persistent or ongoing issue.	80%
7.	Client file has documentation supporting payment with EFA services.	Documentation such as most recent utility bill, number of household members, income information (<i>if applicable</i>), state ID, medical information (<i>if applicable</i>), records describing current & housing needs, description of financial need, and receipt of payment.	80%

Outcome Standards

No.	Standard	Measure	Goal
1.	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 (<i>can be a client report</i>).	80%
2.	Client is prescribed ART (<i>or has notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client was prescribed ART in the 12-month measurement year as documented by the intensive medical case manager and/or clinician.	80%
3.	Client is virally suppressed, has a lowering viral count after ART start, or has a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that the client has a viral load <200 copies/ml at last test as documented by the intensive medical case manager.	80%

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

Service 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 6 month period.	Documentation of agendas/notes, and sign-in sheets reviewed	80%

Outcome Standards

No.	Standard	Measure	Goal
1.	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 (<i>can be client report</i>).	80%
2.	Client is prescribed ART (<i>or has notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client was prescribed ART in the measurement year (<i>can be client report</i>).	80%
3.	Client is virally suppressed, has a lowering viral count after ART start, or has a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that client had less than 200 copies/mL at last HIV Viral Load test during the measurement year (<i>can be client report</i>).	80%

EHE Standard of Care: Non-Medical Case Management 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 clients and will be used as contract requirements, in program monitoring, and in quality management.

Service Category Definition

Non-Medical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management Services have the objective of providing guidance and assistance in improving access to needed services whereas Medical Case Management services have the objective of improving health care outcomes.

The overall treatment goal of non-medical case management services is to provide housing and benefit coordination for people living with HIV/AIDS that will enable medical adherence and stability for each individual client.

Services may focus on:

- Housing coordination and referral assistance to enable an individual to gain or maintain access to and compliance with HIV related medical care and treatment.
- Benefit coordination to include assisting eligible clients to obtain access to other public and private programs for which they may be eligible.

Key activities include:

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

Subservices in CAREWare

Non-Medical Case Management 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 Non-Medical Case Management Service

Service Standards

No.	Standard	Measure	Goal
1.	Client file includes documentation of the date of each encounter.	Documentation of date of encounter evident in client chart.	80%
2.	Client file includes documentation of the duration of each encounter.	Documentation of duration of encounter evident in client chart.	80%
3.	Client file includes documentation of type of each encounter (e.g. face-to-face, phone, etc.).	Documentation of type of encounter evident in client chart.	80%
4.	Client file includes documentation of key activities performed during each encounter.	Documentation of key activities of each encounter evident in client chart.	80%
Non-Medical Case Management – Benefit Coordination Only			
1.	Services are focused on assisting client in obtaining access to both public and private benefit programs for which they may be eligible.	Documentation that services tie to benefit coordination evident in client chart.	80%
Non-Medical Case Medication – Housing Specialist Only			
1.	Client file includes a completed individual care plan specific to housing.	Documentation of completed housing plan evident in client chart.	80%
2.	Client file includes documentation that services are focused on housing information and referrals to enable an individual to gain or maintain access to and compliance with HIV-related medical care and treatment.	Documentation of activities evident in client chart.	80%
3.	Client file includes documentation of completed housing inspection in situations where client relocates.	Documentation of activities evident in client chart, including housing inspection verified by housing case manager.	80%

Outcome Standards

No.	Standard	Measure	Goal
1.	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 the client chart (<i>can be client report</i>).	80%
2.	Client is prescribed ART (<i>or has notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client had less than 200 copies/mL at last HIV Viral Load test during the measurement year (<i>can be client report</i>).	80%
3.	Client is virally suppressed, has a lowering viral count after ART start, or has a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that client was prescribed ART in the 12-month measurement year. (<i>can be client report</i>).	80%

EHE Standard of Care: (Other Professional Services) Legal 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

Other Professional Services allow for the provision of professional and consultant services rendered by members of professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PWH and involving legal matters related to or arising from their HIV status, including assistance with public benefits such as Social Security Disability Insurance (SSDI), interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the HRSA RWHAP, and preparation of: healthcare power of attorney, durable powers of attorney, and living wills.

Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney, preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

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

Exclusions: Funds under this service category may not be used for criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

Subservices in CAREWare

Other Professional 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 Legal Eligibility and Benefits Intervention

EHE Legal Housing Related Intervention

EHE Legal - Other Services

Service Standards

No.	Standard	Measure	Goal
1.	Legal services are provided by qualified professionals. Attorneys must be current members of the Ohio Bar by the Board of Bar Overseers or other similar body. Licensed volunteer attorneys, law students, law school graduates and other legal professionals (acting under the supervision of a member of the bar) may be used to expand program capacity. Paralegal Staff must be supervised by a member of the bar.	Certifications and Licenses of all staff funded through EHE on file at the agency and documented through staff personnel records.	100%
2.	Documentation is maintained of a written policy that identifies allowable and unallowable legal services funded by EHE.	Written policy with assurances regarding billing for services that are unallowable through EHE funds on file and documented.	80%
3.	Client file must include a documentation of the need for legal services to support HIV care, treatment and health outcomes. Service agreements will be developed and signed by both the attorney and the client.	Documentation of the need for legal services to support HIV care, treatment and health outcomes included in client file. Service agreement is signed by both the attorney and client.	80%
4.	Documentation for legal services provided must include attorney name, client name, duration of service, rate, type of service provided, (for example, legal consultation, in-person representation of client, developing written legal documents, phone call etc.). The legal matter addressed does not need to be included in this documentation.	Written documentation including the required information about the legal service provided is documented in the client file.	80%
5.	The legal provider must have an established fee structure, intake process, and case closure policies. Clients must be informed of these criteria before receiving services and related documentation must be included in the client's chart.	Documentation including written policies for intake process and case closure procedures and fee schedule are readily available to clients at the agency. A signed client acknowledgement of this documentation (fee schedule, intake process, case closure process prior to receiving service) is documented in the client file.	80%
6.	The legal provider must have reasonable caseloads and cases must be accepted on priority basis. If the provider uses a wait list, they must have a policy in place that ensures that the wait list is appropriately managed and updated; and that they communicate the client's place on the wait list regularly.	Written policies and procedures for caseload management and case closures on file at the agency.	80%

Outcome Standards

No.	Standard	Measure	Goal
1.	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 (<i>can be client report</i>).	80%
2.	Client is prescribed ART (<i>or has notation from a clinician explaining why they are not prescribed ART</i>).	Documentation that client was prescribed ART in the measurement year (<i>can be client report</i>).	80%
3.	Client is virally suppressed, has a lowering viral count after ART start, or has a clinician's note explaining why ART is not effective at suppressing viral load.	Documentation that client had less than 200 copies/mL at last HIV Viral Load test during the measurement year (<i>can be client report</i>).	80%

Licensing

To practice law in Ohio, an attorney must be admitted to practice (granted a license) by the Supreme Court of Ohio and must maintain that license in good standing.

EHE Standard of Care: (Outpatient & Ambulatory Health Services) Mobile Health Clinics

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

Mobile Health Clinic (MHC) Services facilitate access to HIV care for difficult-to-reach populations living in the zip codes with the highest HIV prevalence and medical deserts for HIV care. MHC provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: mobile vans, using telehealth technology, home visits and other nontraditional settings for HIV-related care. MHCs expand services beyond fixed locations and/or offer services during non-traditional hours. The use of MHCs is a means of reengaging and retaining PWH in Cuyahoga County who have fallen out of care, helping improve the quality of life for participants.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:

Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.

Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category. Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

For standards related to EHE medical care on mobile health clinics, particularly EHE-funded (OAHS) Rapid Start ART and Intensive Medical Case Management, please refer to those specific standards for guidance. For other medical care standards funded under Ryan White Part A Program, please refer to the RWPA Standards of Care.

Subservices in CAREWare

Mobile Health Clinics 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 Mobile Clinic Labs
EHE OAHS Mobile Clinic Physician Visit
EHE OAHS Mobile Clinic Service Coordination

Service 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.	Care being provided by health care professionals is taking place in nontraditional hours (evenings and/or weekends) in high prevalence zip codes.	Documentation of travel dates and times available for review.	80%
3.	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 (<i>as appropriate</i>) • Discussion of risk reduction, HIV education, secondary prevention, and behavior modification (<i>as appropriate</i>) • Medications (<i>including a current list of prescribed medication or notations explaining the absence of prescriptions</i>)	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 <i>(as appropriate)</i> .		
4.	Clients receiving MHC services are provided follow-up by a peer navigator, social worker, or medical provider within 90 days of initial visit.	Documentation of contact made, contact attempt(s), follow-up medical visit, viral load, and/or CD4 test 90 days post-visit.	80%
5.	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%

Outcome Standards

No.	Standard	Measure	Goal
1.	Clients receiving Mobile Health Clinic 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%
2.	Clients receiving Mobile Health Clinic services are prescribed ART at first appointments or interaction with provider.	Documentation that client was prescribed ART at the onset of care; within 72 hours of diagnosis (maximum of 14 days).	80%
3.	Clients receiving Mobile Health Clinic services are lowering their viral count during first 6 months of care <i>(Not applicable if client is newly diagnosed within the last 6 months of the measurement year)</i> .	Documentation that the client has a viral load <200 copies/mL after 6 months of care.	80%

Appendix A: Exception Request Form for Emergency Financial Assistance (EFA)

Please print clearly

Date: _____

Form Submitted by:

Name: _____

Title: _____

Organization: _____

Phone: _____

Email: _____

Request Description:

CAREWare ID: _____

Service/Cost: _____

Exception Request Description:

*Please attach any supporting documents, such as proof of necessity.
Please direct questions about completing this form to Erin Lark Turcoliveri at
elark@ccbh.net or (216) 221-2001 x1326.*

FOR CCBH USE ONLY:

DATE SUBMITTED:

DATE RECEIVED:

REQUEST APPROVED: ☐

REQUEST DENIED: ☐

APPROVAL AMOUNT:

NOTES:

SIGNATURE:

Appendix B: Emergency Financial Assistance Gift Card Distribution

Recipient:

I, _____, received the following gift card _____ from
(name) (card number)

_____ in the amount of \$ _____ on this date: _____.
(store) (value of card) (date)

Agency:

I will be distributing this card to a community member receiving services with my agency. The purpose of the emergency financial assistance is _____.

I have informed the recipient that they will not be permitted to use this card for the purchase of the following items: alcohol, tobacco, illegal drugs, or firearms. I also have informed the recipient that they will not be permitted to exchange the card for cash.

(recipient signature)

(date)

(staff/agency signature)

(date)