



HIV CARE PROGRAM

MINORITY AIDS INITIATIVE

PROGRAM GUIDANCE

May 2012

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PROGRAM OVERVIEW

The California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) is pleased to provide you with the HIV Care Program (HCP) and Minority AIDS Initiative (MAI) Program Guidance. This tool has been revised and provides you with information about program requirements. It is hoped that this tool will assist Contractors to develop and maintain an effective, efficient, and high-quality HCP in their local health jurisdiction (LHJ).

We hope this Guidance will provide you with the technical assistance needed for the management of your HCP. If you require further clarification or technical assistance, your HCP Specialist or MAI Program Specialist is available to assist you.

Please refer to the HCP Operations and Budget Guidance for assistance with budgets, invoicing, reporting, contract monitoring, and similar topics.

Legislation

The [Ryan White HIV/AIDS Treatment Extension Act of 2009](#) was first enacted in 1990 as the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. It has been amended and reauthorized four times: in 1996, 2000, 2006, and 2009. The program is the largest Federal program focused exclusively on HIV/AIDS care and reaches over 530,000 uninsured and underinsured people affected by the virus.

Services Provided

The Ryan White HIV/AIDS Program provides primary outpatient medical care, including dentistry, and support services to individuals living with the disease who lack or have inadequate health insurance or personal financial resources to pay for their own care. Ryan White funding functions as the, “payer of last resort,” covering those who do not qualify for any other health benefits program, including Medicare or Medicaid (known as Medi-Cal in California).

While clinical care and support services are the primary focus of the program, Ryan White also funds training and technical assistance for medical professionals as well as demonstration projects aimed at identifying and slowing the epidemic in high-risk populations. At present, young males of color are at greatest risk.

Program Goals

The services funded by the Ryan White HIV/AIDS Program are intended to reduce the use of costly inpatient care, extend screening and treatment into medically underserved populations, and improve the quality of life for those affected by the epidemic. The program achieves these goals by funding HIV/AIDS care and services through grants to the

State and local governments, health care providers, and community-based organizations (CBOs).

**Federal
Administrative
Structure**

The [Health Resources and Services Administration \(HRSA\)](#), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

The [HIV/AIDS Bureau \(HAB\)](#) of HRSA was formed in August 1997 to consolidate all programs funded under the CARE Act. HAB administers the Ryan White HIV/AIDS Program.

The Ryan White HIV/AIDS Program directs assistance through the following channels:

- Part A** Provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs), areas most severely affected by the HIV/AIDS epidemic.
- Part B** Provides grants to states and U.S. territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Part B grants include the AIDS Drug Assistance Program (ADAP) award.
- Part C** Provides grants directly to service providers such as ambulatory medical clinics to support outpatient HIV early intervention services and ambulatory care.
- Part D** Provides family-centered primary medical care involving outpatient or ambulatory care (directly through contracts or through memoranda of understanding) for women, infants, children, and youth with HIV/AIDS.
- Part F** Provides funding to a variety of programs, including:
 - [The Special Projects of National Significance Program](#) grants fund innovative models of care

and supports the development of effective delivery systems for HIV care.

- [The AIDS Education and Training Centers Program](#) supports a network of 11 regional centers and several national centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS.
- [The Dental Programs](#) provide additional funding for oral health care for people with HIV.
- [The Minority AIDS Initiative](#) provides funding to evaluate and address the disproportionate impact of HIV/AIDS on African Americans and other minorities.

Ryan White Part B Funding in California

[OA](#) implements and oversees the Ryan White HIV/AIDS Program – Part B funding in California under the guidance of HRSA known as HCP. Program goals include:

1. To minimize new HIV infections;
2. To maximize the number of people with HIV infection who access appropriate care, treatment, and prevention services; and
3. To reduce HIV-related health disparities.

OA also oversees MAI. The goal is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color.

OA Funding to LHJs

The HIV Care Branch within OA provides HCP and MAI funding to LHJs. With this funding, OA aims to support the development, implementation, and maintenance of comprehensive and high-quality HCP.

Requirements of all HCP/MAI Funded LHJs

Contractors are given broad discretion to plan many aspects of their program based upon the health care needs of people living with HIV/AIDS (PLWH/A) in their LHJs. Contractors must ensure that essential core medical services and support services will be adequately addressed when setting priority and allocating funds within their LHJ. The [Service Delivery Plan](#) (part of the Scope of Work [SOW]) will assist in this process.

SOW specifies all the services to be performed by the Contractor. Please refer to your contract and specific SOW for details.

Emerging Issues

OA will be working to ensure that Ryan White HIV/AIDS Program funding meets not only our own goals, but supports the goals of other health-related initiatives.

The [National HIV/AIDS Strategy](#) (NHAS) was released in July 2010 and represents the first unified approach to addressing HIV/AIDS in the United States. NHAS delineates three broad goals:

1. To reduce new HIV infections;
2. To increase access and improve health outcomes for people living with HIV; and
3. To reduce HIV-related health disparities.

NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce the potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, NHAS advocates for the adoption of community-level approaches to reduce HIV infection in high-risk communities and reduce stigma and discrimination against people living with HIV.

The **Early Identification of Individuals living with HIV/AIDS (EIIHA)** is a legislative requirement that focuses on individuals who are unaware of their HIV status, and how best to bring HIV-positive individuals into care, and refer HIV negative

Individuals into services that are going to keep them HIV negative. It involves the identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV-positive individuals to medical care.

The goals of this initiative are:

1. Increase the number of individuals who are aware of their HIV status;
2. Increase the number of HIV-positive individuals who are in medical care; and
3. Increase the number of HIV-negative individuals referred to services that contribute to keeping them HIV negative.

***Policy
Notifications***

HCP Management Memos (MMs) are distributed by OA periodically. They provide additional information and clarification regarding administration and use of HCP funds. MMs may also request information or acknowledgement of program compliance within a limited time frame. It is very important that project directors, fiscal agents, and/or service providers are aware of these MMs and respond by the requested due date. It is recommended that HCP MMs be retained for reference. In the event you need a copy of previous MMs, consult your OA Care Operations Advisor for assistance.

OA MMs are often a result of clarification of grant policy with regards to administration and use of funds. It is recommended to review the HRSA Policy Notice and Program Letter website at: <http://hab.hrsa.gov/manageyourgrant/policiesletters.html> frequently or by [clicking here](#).

***How to Use this
Document***

This Guidance is designed to provide Contractors with the technical assistance needed for the management of your HCP. If you require further clarification or technical assistance, your HCP Specialist or MAI Program Specialist is available to assist you.

When read online, this document provides hyperlinks to additional resource available on the World Wide Web.

HIV Care Program (HCP)

The goal of HCP is to serve uninsured and underinsured clients with HIV disease, who do not have access to primary care-related services and/or support services. HCP fills gaps in care not covered by other sources of coverage. Each LHJ and CBO is expected to go through their local planning process to determine the specific care and support needs within the service area. HCP is a flexible, two-tiered approach to service prioritization, provision and delivery and is based upon the HRSA-defined service categories, both Core Medical and Support Services.

Service Overview

HIV care services are funded using a Single Allocation Model to consolidate program funds into a single contract in each LHJ. The Contractor agrees to administer HCP and to ensure the provision of HIV care services as described in the SOW. The Contractor may provide direct client services exclusively or subcontract all or parts of the client services. If all or parts of client services are subcontracted to other client service providers, the Contractor must ensure all services provided by the subcontracted agency will be in accordance with HCP.

The Contractor will plan, develop, and ensure the delivery of Outpatient/Ambulatory Medical Care for HIV-positive individuals. Additionally, the Contractor will plan, develop, and ensure the delivery of related Core Medical and Support Services, as funds permit. These services should be designed to meet the identified needs of individuals with HIV disease in the service area.

Services to be Performed

The HIV care services to be provided under HCP are consistent with HRSA-defined service categories. For a list of HRSA Core Medical and Support Service categories, see Appendix A.

Tier I

HCP prioritizes the HRSA category *Outpatient/Ambulatory Medical Care* as a Tier I service. There are additional HRSA Core Medical Services allowable in Tier I which include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, prescribing and managing medications.

Tier II

Tier II services support access to Tier I care, maintenance in Tier I care, and reduce the risk of treatment failure and/or HIV transmission. To provide the greatest flexibility to local providers, the following list of HRSA service categories included in Tier II of HCP is extensive and varied.

- Case Management (non-medical)
- Child Care Services
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation Services
- Outreach Services
- Psychosocial Support Services
- Referral - Health Care/Supportive Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services-(residential)
- Treatment Adherence Counseling

Eligibility for HCP Services

Individuals with HIV/AIDS are eligible for HCP services. Service providers must confirm that the individual is HIV positive and has a need for services for which there is no other payer source.

There are three exceptions to this eligibility criteria:

1. Veterans;
2. American Indian/Alaskan Natives; and
3. Affected Clients.

Veterans

HCP providers may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White services. HCP providers should refer eligible veterans to the Veterans Administration (VA) for services, when appropriate and available. In cases where the VA does not provide needed services, the Ryan White HIV/AIDS Program would fulfill its obligation as payer of last resort.

For more information, please refer to [HAB Policy Notice 07-07](#).

American Indian/Alaskan Natives

Any American Indian or Alaska Native who is otherwise eligible to receive Ryan White services may request and must receive those services regardless of whether or not they are also eligible to receive the same services from the Indian Health Services (IHS), and regardless of whether or not those IHS services are available and accessible to the American Indian or Alaskan Native.

HCP providers cannot deny services based on American Indian or Alaskan Native status. However, individuals must meet the

same established eligibility criteria as all other individuals receiving care through HCP.

For more information, please refer to [HAB Policy Notice 07-01](#).

Affected Clients

HAB defines affected clients as: 1) being HIV negative or having an unknown HIV status; 2) being a family member or partner of an individual who is HIV positive; **and** 3) receiving at least one Ryan White-funded support service during the fiscal year. Family members or partners who are HIV positive are considered primary clients, rather than affected clients.

In some circumstances **affected clients** may be candidates for Ryan White HIV/AIDS Program services in limited situations and LHJs, but these services for non-infected individuals must always benefit their HIV-positive partner or family member.

For more information, please refer to [HAB Policy Notice 10-02](#). For instruction on entering Affected Clients into AIDS Regional Information and Evaluation System (ARIES), please refer to [ARIES Policy Notice No. C5](#).

Service Delivery Plans

Service Delivery Plans provide a road map for the development of a system of care and a blueprint for the complex decisions that must be made about planning, developing, and delivering comprehensive HIV services in communities.

There are six sections to the Service Delivery Plan. They include:

- Needs Assessment Summary;
- Resource Inventory;
- Priority Setting and Resource Allocation;
- Description of Service Delivery;
- Goals and Objectives; and
- Effective Measure.

HCP requires that Contractors in Direct Service Areas develop a three-year Service Delivery Plan at the beginning of the three-year contract cycles. Contractors are solely responsible for the completion of the Service Delivery Plan; this responsibility cannot be subcontracted to another organization.

Contractors are required to gather community input and consult with service providers when updating Service Delivery Plans.

Contractors in EMAs and TGAs can submit the most current Comprehensive Plans in place of the Service Delivery Plans.

Additional information about the Service Delivery Plan can be found on OA's website by following this [link](#).

Scope of Work (SOW)

The SOW becomes part of legally binding documents within the contract. The SOW describes the target audience, as well as the goals, objectives, and specific activities the Contractor will work towards over the contract period. The SOW provides the framework for programming and evaluation.

Currently, the SOW is included as Exhibit A of the contract and includes both programmatic and fiscal requirements.

The programmatic requirements include:

- Provision of comprehensive and ongoing medical services to individuals with HIV/AIDS;
- Provision of other Core Medical and Support services as necessary;
- Develop and implement a Service Delivery Plan;
- Coordinate and advisory and/or focus group;
- Ensure the protection clients' privacy and confidentiality at all times;
- Ensure subcontracted agencies are able to support program services and activities, and perform quality assurance and utilization review activities for subcontracted HIV care services;
- Develop and maintain working relationships with entities who provide key points of entry into medical care;
- Ensure case management services for individuals living in rural areas, as appropriate;
- Ensure HIV care services are provided in setting accessible to low-income individuals with HIV disease;
- Provide targeted prevention coordinated with all state and federal programs to low-income individuals with HIV disease;
- To the maximum extent practical, ensure that HIV-related health care and support services will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease;
- Ensure that services provided to women, infants, children and youth are tracked and reported;
- Ensure that services provided under this contract are in

accordance with the program policy guidance issued by Division of Service Systems (DSS), HIV/AIDS Branch and OA; and

- Ensure MMs responses are accurate, complete, and received on or before the required due date.

OA is currently redesigning the format for the SOW for programmatic activities into the more standard chart format to describe goals, objectives, activities, evaluation measures and timeframes. More information will be forthcoming.

Reporting Requirements

The [Quarterly Narrative Report](#) provides an opportunity for Contractors and service providers (if under a subcontracted agency) to describe general accomplishments, issues or concerns, as well as any technical assistance and/or training needs.

Please refer to the Operations and Budget Guidance for fiscal reporting requirements.

ARIES

[ARIES](#) is a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES allows Ryan White-funded service providers to automate, plan, manage, and report on client data.

Client Consent and Share Options

Clients may choose whether or not to share their ARIES data with other agencies at which they receive services. Information shared between these agencies may include client demographics, contact information, medical history, and service data. However, information related to mental health, alcohol and substance use, and legal services cannot be shared between service providers regardless of a client's share status.

HCP providers are required to: 1) inform clients about the share options and their agency's privacy practices; 2) have clients complete and sign the ARIES Client Consent Form; 3) ensure that the share status to which clients have agreed is reflected appropriately on the "Agency Specifics" screen in ARIES; and 4) enter the "ARIES Consent Form" on the "Eligibility Documents" screen in ARIES.

It is imperative that all ARIES users understand and comply with the procedures for consenting clients as outlined in [ARIES Policy Notice \(APN\) C1](#).

Data Collection and Reporting

While ARIES is meant to be used in real-time, not all HCP providers are able to meet this goal. Therefore, providers are required to enter data into ARIES within two weeks from a client's date of service (see [APN E1 – Timeliness of Data Entry](#)).

HCP providers are required to collect the HCP minimum dataset (see [APN E2 – Completeness of Data Entry](#)), which includes data elements required by:

- HRSA to complete the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report.
- OA for its development of estimates and reports (i.e., estimate of unmet needs for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to conduct program activities.

As part of OA's Data Improvement plan, HCP providers may be contacted by OA to resolve any data quality problems (e.g., missing data).

HCP providers must electronically submit RSR through HAB's RSR Web Application System. RSR is comprised of two reports: The Provider Report and the Client Report, which contains an XML file with their client-level data.

HCP providers must submit their completed RSR to the RSR Web Application System by February 15 each year. The RSR reporting period is January 1 through December 31 of the previous year. HCP providers must check the RSR Web Application System until notified that their RSR has been successfully submitted to HRSA.

The vast majority of HCP providers manually enter data directly into ARIES. Some providers may want to import their data from electronic medical record or other data systems into ARIES. Such requests must be made formally following the procedures outlined in [APN G3 – ARIES Imports](#). Only those requests that have been vetted and approved by OA's Program Evaluation and Research Section will be permitted to import data into

ARIES. **Under no circumstances** may providers use HCP or other OA funds to develop or maintain their import systems.

Client Confidentiality and Security

Client confidentiality and security are primary concerns. ARIES was designed to maximize the protection of client data (e.g., role-based permissions which allow users access to client information based on their work needs) and includes sophisticated security features (e.g., digital certificates and data encryption) (see [APN A1 – Establishing New Users](#) and [APN B2 – Users Logins and Password](#)). The ARIES computer servers are housed at the State's Data Center, which maintains additional security precautions (e.g., firewalls and intrusion detection software).

All ARIES users are required to take all necessary steps to protect the security and confidentiality of the Protected Health Information entered and stored in ARIES. Users must follow the Agency's/Provider's guidelines pertaining to patient confidentiality and the Health Insurance Portability and Accountability Act. To this end, all ARIES users must read and comply with the security-related ARIES Policy Notices (see [APN B1, B2, B3, and B4](#)).

For more information about ARIES policies and procedures, training and technical assistance, and forms, policy notices, and documentation, please visit www.projectaries.org or contact the ARIES help desk at 1 (866) 411-ARIES (2743).

***Technical
Assistance
Contact***

Patricia McGowan, HCP Policy Specialist
Phone: (916) 449-5951
E-Mail: Patricia.McGowan@cdph.ca.gov

MINORITY AIDS INITIATIVE (MAI)

MAI was established by Congress in 1999 in response to the impact of HIV/AIDS on racial and ethnic minorities. Administered by HRSA, MAI addresses the HIV/AIDS care needs of African Americans and other disproportionately impacted communities. MAI focuses on improving HIV-related health outcomes to reduce existing racial and ethnic health disparities.

The goal of MAI is to increase access to, and engagement in, HIV/AIDS medical care for HIV-positive persons of color, including access to ADAP, Medi-Cal, or other appropriate programs providing HIV medications. This goal is achieved by providing outreach and treatment education to HIV-infected persons of color **who have never been in care, who know they are HIV positive, or who have been lost to care.**

Under Part A, MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by the epidemic. Under Part B, MAI formula grants fund outreach and treatment education services designed to increase minority access to needed HIV/AIDS medications through State Part B ADAP or other sources for treatment.

Part B MAI planning activities should be coordinated with all other local funding streams for HIV/AIDS to: 1) maximize education and outreach strategies to link racial and ethnic minorities to ADAP; and 2) reduce duplication of services and efforts.

OA receives MAI funding as part of the Ryan White Part B grant award. MAI funds are allocated to a certain number of LHJs also funded with Ryan White Part B dollars each year. The allocation formula includes the most recent data on the number of living non-white HIV/AIDS cases in funded counties. Please [click here](#) to access the MAI allocation description and the current list of funded counties.

Service Categories

MAI services are specifically for HIV-infected persons of color who have never been in care despite an awareness of their HIV-positive status or who has been lost to care.

In accordance with HRSA policy, there are only two allowable service categories for Part B MAI:

1. Outreach; and
2. Treatment Education.

These service categories are designed to meet the needs of persons of color in order to ensure that clients can access, engage in, and remain in care; receive help in adhering to treatment; and be provided with education and support that will enable them to become active participants of their own health care and improve their overall quality of life.

Outreach

For the purpose of MAI funding, outreach is defined as those activities typically performed by an outreach worker that results in:

1. Identifying HIV-infected persons of color who know their status but have never been in care or who have been lost to HIV medical care;
2. Removing barriers that have prevented access to HIV medical care; and
3. Establishing engagement in HIV medical care.

Outreach services should be conducted in times and in places where there is a high probability that persons of color with HIV infection will be reached.

MAI outreach services do NOT include routine HIV counseling and testing or HIV prevention education. These services may be provided on a case-by-case basis for a specific MAI client only when the service is necessary to remove a barrier to care for that client.

Treatment Education

For the purpose of MAI funding, treatment education is defined as providing health education, treatment adherence, and risk reduction information to HIV-infected persons of color who know their HIV status but are not accessing care or to HIV-infected persons of color who are lost to care.

Information includes educating clients living with HIV about:

- How to communicate with medical providers;
- The importance of treatment adherence;
- How to manage medication side effects;
- How to understand their laboratory results;
- How to improve their health status;
- How to reduce HIV transmission; and
- How to identify medical and psychosocial support services and counseling that are available locally.

Priority Populations

HIV-infected persons of color who have never been in care, who know they are HIV positive, or who have been lost to care are the priority populations for MAI services.

California's communities of color, primarily African American and Latino, are historically underserved. These populations

are at a greater risk of not being linked to care shortly after HIV diagnosis, fail to adhere to treatment and fall out of care.

SOW

SOW becomes part of legally binding documents within the contract. SOW describes the target audience, as well as the goals, objectives, and specific activities the Contractor will work towards over the contract period. SOW provides the framework for programming and evaluation.

OA is currently working to develop a SOW for MAI. More details will be shared once available.

Reporting Requirements

The [Quarterly Narrative Report](#) provides an opportunity for Contractors and service providers (if under a subcontracted agency) to describe general accomplishments, issues or concerns, as well as any technical assistance and/or training needs.

Please refer to the Operations and Budget Guidance for fiscal reporting requirements.

Quarterly narrative reports are due 45 days after the last day of the reporting period. Please refer to the HCP Operations and Budget Instructions for specific due dates. Please submit the Quarterly Narrative Report to the OA Care Operation Advisor.

Data Collecting and Reporting

Efforts are currently underway to incorporate MAI data into ARIES through the Anonymous Client Enhancement project. Until MAI reporting is incorporated into the ARIES data reporting system, Contractors must track and report activities manually.

Contractors receiving MAI funds must track and report their outreach activities and treatment education services to OA. The reporting requirements gather information on demographics and program activities. The information from these reports is used to comply with the reporting requirements from HRSA that contribute to showing program success and planning future program activities.

The required [reporting forms](#) are the Client Demographic Reporting Form and Client Contact Reporting Form. Instructions for completing the forms are available on the website.

Please refer to the HCP Budget and Operations Guidance for fiscal reporting requirements.

Client Demographic Report Form

- Submitted monthly, 30 days after the reporting month;
- Completed by MAI outreach worker;
- Records demographic data when **first** contact is made with an MAI client; and
- Updated form is submitted when additional demographic information is obtained.

Client Contact Reporting Form

- Submitted monthly, 30 days after the reporting month;
- Completed by MAI outreach worker;
- Provides progress status on MAI clients served; and
- Submitted with corresponding original or revised Client Demographic Report for listed MAI clients.

Contractors should review notifications regarding changes to MAI forms and instructions. It is important for Contractors to use the most current versions of the MAI forms in order for OA to collect the required data.

MAI Client Demographic and Client Contact forms are due:

Reporting Form	Report Due Date
Client Demographic Reporting Form	30 days after the reporting month
Client Contact Reporting Form	30 days after the reporting month

Data reports are submitted to Christopher Paular via fax at (916) 449-5959 or e-mail at: Christopher.Paular@cdph.ca.gov. Also, copy the MAI Program Policy Specialist.

Technical Assistance Contact

Genellee Paras, MAI Program Policy Specialist
Phone: (916) 650-6612
E-Mail: Genellee.Paras@cdph.ca.gov

DATA AND QUALITY MANAGEMENT (QM)

HIV-related morbidity and mortality has dropped dramatically due to advances in HIV/AIDS treatment. However, reductions are uneven across HIV-infected populations due to unequal access to care and variable quality of services provided. QM seeks to enhance the quality of HIV care provided and increase access to services. By measuring how health and social services meet established professional standards and user expectations.

The reauthorization of Ryan White funding in 2000 stressed quality management in the following areas:

- Care should follow established guidelines;
- Quality includes helping people receive appropriate care; and
- Data can support the improvement of quality and also provide information about the state of the HIV/AIDS epidemic.

HRSA's HAB quality initiatives, which focus on the service delivery system at various levels, are designed to help grantees implement QM programs that target clinical, administrative, and supportive services. HRSA HAB stresses five elements:

1. Use a systematic process;
2. Establish benchmarks;
3. Be focused;
4. Be adaptable; and
5. Seek improved outcomes.

OA uses ARIES to collect, and analyze client level data to inform QN activities, including:

- Generating HAB Performance Measures;
- Preparing for contractor site visits;
- Identification and selection on client charts to be reviewed; and
- Measure quality of care and program compliance.

ARIES

ARIES is a custom, web-based, centralized HIV/AIDS client management system. The project grew out of a combined effort by the State of Texas, the County of San Diego, the County of San Bernardino, and the State of California. ARIES provides a single point of entry for clients and supports coordination of client services among providers. It meets both HRSA and State care and treatment reporting requirements and provides comprehensive data for program monitoring and scientific evaluations.

Working with providers to organize, plan, manage, and report on available services furthers the goal of helping clients who suffer with AIDS. Through high-quality automated service tracking and reporting, ARIES centralizes client data, service details, and agency and staff information, giving agencies a more complete picture of a client's care plan and the services available.

Maximizing the quality of client services in this way results in better care. In addition, the use of ARIES by many agencies leads to the simplification of service referrals: with the client's permission, agencies can share an individual client's records.

ARIES administrators can customize the Web application for the individual agency by designing new reports and creating custom data fields.

Typical uses of ARIES available to agencies include:

- Intake – enroll clients and enter their records; and
- Case management – complete assessments, create care plans, enter case notes, make referrals, and associate clients with services.

Service Providers, Clinicians – access schedules, enter client notes, approve treatment plans.

- Agency management – generate reports to track costs, services, reimbursements, and grant writing; and
- Research – evaluation programs, analyze aggregate reporting and data while maintaining client confidentiality.

QM

QM requirements were introduced to establish clinical QM programs to assess the extent to which HIV health services are consistent with the most recent Public Health Services (PHS) [guidelines](#) for the treatment of HIV disease and related opportunistic infections, as well as helping to ensure the delivery of quality services to eligible clients.

The [HAB HIV Performance Measures](#) represent clinical decision points that align with the National HIV/AIDS goal of increasing access to care and improving health outcomes for PLWH/A.

OA monitors five of the measures in [Group 1](#) of HAB's HIV/AIDS Core Clinical Performance Measures for Adult/Adolescent Clients and three non-clinical indicators.

HAB Group 1 HIV/AIDS Clinical Performance Measures for Adults and Adolescents include the following:

- **HAB Group 1, Measure 1:**
Medical Visits
OA Goal: 75 percent
Percentage of clients with HIV infection who had two or more medical visits three or more months apart in an HIV care setting in the measurement year
- **HAB Group 1, Measure 2:**
CD4 T-Cell Count
OA Goal: 75 percent%
Percentage of clients with HIV infection who had two or more CD4 T-cell counts performed at least three months apart during the measurement year.
- **HAB Group 1, Measure 3:**
Pneumocystis Pneumonia (PCP) Prophylaxis
OA Goal: 75 percent
"Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm³ who were prescribed PCP prophylaxis."
- **HAB Group 1, Measure 12a:**
Antiretroviral Therapy
OA Goal: 75 percent
Percentage of clients with AIDS who are prescribed highly active antiretroviral therapy.
- **HAB Group 1, Measure 17:**
Antiretroviral Therapy for Pregnant Women
OA Goal: 100 percent
Percentage of pregnant women with HIV infection who were prescribed antiretroviral therapy.

OA measures statewide and individual provider performance by running the HAB QQM Indicator Report (QM reports) built into ARIES. ARIES calculates the clinical performance measures based on HAB's definition of the numerator and denominator, patient exclusions, and data elements.

OA staff monitors the performance of the non-clinical measures through chart reviews, contract monitoring reviews, and data quality checks.

HCP Contractors and service providers using ARIES can monitor their progress in meeting HAB Group 1 and 2 clinical performance measures (except the lipid screening in Group 2 by running QM reports. Unlike the HAB QM Indicators, specific reports for the non-clinical indicators are not available in ARIES. However, providers can run the "Fix-It" reports for insurance, poverty level, and eligibility documents to identify and resolve data quality related to these indicators.

The three non-clinical indicators OA monitors include:

1. Percentage of clients with documentation of HIV status;
2. Percentage of clients with poverty level indicated; and
3. Percentage of clients with documentation of insurance status.

These measures help direct service provider's attention on payer of last resort mandated requirements and helps to identify service providers who need assistance with improving their performance.

QM Programs

The purpose of a QM program is to identify and remedy problems, barriers, and program deficiencies in order to improve access to, and quality of, health care and supportive services. QM programs are continuous and systematic processes with identified leadership, accountability, and dedicated resources which use data and measurable outcomes to determine progress towards relevant, evidence-based benchmarks. QM programs should also focus on linkages, efficiencies, and provider and client expectations in addressing outcome improvement and be adaptive to change

The QM plans should describe:

- Roles and responsibilities of staff members and/or committees overseeing QM activities;
- QM indicators and benchmarks to assess and monitor the quality of services provided;
- Data collection process utilized;
- QM activities used for data analysis; and

- Process for developing and implementing an improvement plan.

Contractors are required to ensure that all client service providers have a QM program in place. The QM program should fit within the framework of the client service providers' other programmatic quality assurance and quality improvement activities. Client service providers may use an existing QM program (e.g., Joint Commission on Accreditation of Healthcare Organizations, Medicaid) or develop their own program.

Client service providers who develop their own program should refer to HRSA's [Quality Improvement Tools and Resources](#).

Contractors are also required to incorporate selected indicators from Groups 1 and 2 of HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents into QM programs. Specific indicators will be identified and released by OA MMs.

Contractors and subcontracted agencies can monitor their progress in meeting HAB QM indicators for Groups 1 and 2 by using the Compliance Reports in ARIES as appropriate.

ADDITIONAL PROGRAM REQUIREMENTS

Program Monitoring

In accordance with Ryan White HIV/AIDS Program, OA monitors HCP contracts. The goal of contract monitoring is to ensure compliance with state and federal contract requirements. OA is committed to providing technical assistance to Contractors and service providers to ensure continued compliance.

In 2011, HRSA implemented National Monitoring Standards for performance measures. OA monitoring tools and internal processes were revised as a plan to implement the HRSA standards. Contract performance monitoring will be performed in accordance to HRSA's National Monitoring Standards.

NATIONAL MONITORING STANDARDS

Implementing HRSA's National Monitoring Standards is a process comprised of a set of systems that address all monitoring components of the HRSA standards including, but are not limited to:

- a. *Fiscal Monitoring*: A system to assess the appropriate use of funds including the control, disbursement, use and reporting of allowable costs; and
- b. *Program Monitoring*: A system to assess whether allowable services are provided to eligible clients according to service limits. Program monitoring may include reviewing program reports, conducting site visits, and reviewing client records or charts.

OA implementation process of the National Monitoring Standards includes a variety of contract monitoring methods to include audit reviews, desk audits, and site visits. Infrastructures around site visit preparations, chart reviews, and six-month re-certifications are being developed in accordance with the HRSA National Monitoring Standards. Contractor and Service Provider requirements set forth by HRSA can be accessed on OA's website at:

<http://www.cdph.ca.gov/programs/aids/Pages/HCPNatlMonitoringStds.aspx>.

Contractors are required to provide any needed assistance to the State in carrying out its monitoring activities, including, but not limited to making available all records, materials, data information, and appropriate staff to authorized State and/or Federal representatives. Additionally, for all deficiencies cited in the monitoring report, the contractor will develop a corrective action plan (CAP), submit to the

State for approval and implement the plan. The CAP must be submitted to the State within 30 days of receipt of the monitoring report.

On-going program monitoring will also be conducted by evaluating progress towards the objectives described in SOW. Additional information will be forthcoming regarding the requirements to submit SOW progress reports.

***Linkage to Care
(LTC)***

The LTC model is a standard service to navigate HIV-positive individuals through care once they know their HIV-positive result. While LTC is not a new approach, OA's HIV Care Branch is working collaboratively with the HIV Prevention Branch to support LTC as a priority activity for all OA-funded HIV testing sites, as well as HCP Contractors.

LTC is considered to be achieved when a newly diagnosed HIV-positive person is seen by a health care provider to receive medical care for his or her HIV infection, usually within a specified period of time. The Centers for Disease Control and Prevention defines that time period as within 90 days. The term LTC is used by OA in the context of referral to, and verification of a medical visit, and not for other types of referrals (to case management, for example).

LTC and retention in care, are important for several reasons:

- Early initiation of HIV treatment and long-term adherence leads to better health outcomes and reduces transmission of infection;
- LTC soon after HIV diagnosis provides opportunities for intervention to prevent transmission; and
- Many people living with HIV are not linked to care soon after diagnosis or do not stay in care

HCP Contractors are encouraged to collaborate with local HIV testing coordinators and other prevention program staff to develop effective approaches to LTC in the community.

The models for LTC may vary depending upon the setting in which HIV testing is performed (i.e., jail, health center, drug treatment center). Each facility is unique, so a single model or approach may not be effective. There are a variety of factors to be considered when developing LTC approaches, including patient population, facility capacity, organization and logistical features of the facility, staff skills and engagement and resources.

Retention and Re-Engagement in Care

OA supports and encourages collaborative work between HCP providers and those working in HIV prevention to increase the percentage of newly-diagnosed HIV-positive individuals that are linked to and retained in HIV primary care, and to re-engage people who have been lost to care.

HCP and MAI Contractors are expected to collaborate with prevention providers and Ryan White Part C (Early Intervention) program providers to develop a comprehensive model to identify out-of-treatment HIV-positive individuals, and engage and retain HIV-positive people in treatment, especially those who are hard to reach, experience social, cultural, or economic barriers to care, or are at risk of “falling through the cracks” and failing to access and fully use health care.

Each LHJ is responsible for determining the most effective approaches for achieving active collaboration between local care and prevention providers with the goal of achieving LTC and continued engagement in care for HIV-positive individuals. Examples of collaboration include:

- Educating HIV-positive individuals about care eligibility criteria and available benefits;
- Offering assistance in negotiating care systems;
- Identifying potential barriers to care and providing assistance in overcoming them;
- Assessing individuals for their risk of being lost to care and helping them remain engaged;
- Assisting newly-diagnosed individuals in making and keeping initial care appointments;
- Providing initial and ongoing HIV treatment education and adherence support; and
- Following up on referrals outside of the care setting in order to monitor client progress, offer support, and address barriers, as needed.

EIHA Plan

The legislative requirements for the EIHA initiative aims to identify, inform, and refer diagnosed and undiagnosed individuals to appropriate HIV/AIDS care services, as well as link individuals who are newly diagnosed with HIV to care.

EIHA activities align with the NHAS goals which include:

- Minimize the number of new HIV infections;
- Maximize the number of HIV-infected individuals who access appropriate care, treatment, and support services; and
- Reduce HIV-related health disparities.

Through existing program activities, including MAI (in certain LHJs), LTC and Retention and Re-Engagement in Care, Contractors are already performing the goals of EIHA for the general population in their communities.

In order to achieve related goals as described in NHAS, OA is using the EIHA initiative to specifically target priority populations at disproportionate risk of becoming infected with HIV or once determined to be positive, not accessing appropriate HIV care, treatment, and support services.

Through a health disparities approach utilizing local epidemiologic, program and care/treatment data, OA has identified five high-risk populations for EIHA activities:

1. African American and Latino men who have sex with men (MSM);
2. Male injection drug users who have sex with men (IDU-MSM);
3. African American women and Latinas;
4. Undocumented Latinos (both male and female); and
5. Transgender youth.

In order to demonstrate an effective EIHA plan, OA is requiring HCP Contractors to demonstrate active collaboration between HIV prevention and HCP providers at the local level in reaching the high-risk population listed above.

To create your plan, follow these guidelines:

1. Examine available epidemiologic, demographic, and service utilization data for the following HRSA's Parent Populations and Target Populations table below.

Parent Populations	Target Populations
MSM	African American Latino
Substance Abusers/IDUs	MSM
African American	Women
Hispanic	Women Undocumented (non-gender specific)
Transgender	Youth (13-24 years)

2. Determine which population(s) are the most impacted in your area.
3. Based on your local epidemiological data and relative HIV/AIDS disease burdens, prioritize the target populations in the area. Provide an explanation and justification for the prioritized list of target population(s).
4. List the proposed delivery areas and the allocation of care/treatment-related service categories (i.e., Outreach and/or Early Intervention Services [EIS]) you intend to implement for your EIIHA activities. Include in your outline the coordination with prevention.
5. Select one or more target groups to provide EIIHA services.
6. Provide a description of how your agency collaborates and integrates with other Ryan White-funded agencies and other partners funded through OA.

The plan should not be more than five pages long and needs to be submitted annually with the budget.

**Screening
Clients for
Program
Eligibility**

Although full implementation of Health Care Reform is scheduled for 2014, changes to HIV services are being implemented now through California’s section 1115 waiver “Bridge to Reform.” New programs that provide HIV care services and treatment are available, and these programs must be understood and considered in routine screening for Ryan White clients. Under the current law, Ryan White HIV/AIDS Program must serve as the “payer of last resort,” meaning Ryan White funds cannot be used to pay for services that could otherwise be paid for by another source.

One example of an emerging program is the Low Income Health Program (LIHP) currently implemented in certain counties, although scheduled for state-wide implementation. For further information on LIHP, please visit OA’s website at:

<http://www.cdph.ca.gov/programs/aids/Pages/OARyanWhiteDHCSLowIncomeHealthProgram.aspx>.

OA has developed technical assistance on LIHP for Ryan White service providers (case managers and benefits counselors), that can be accessed at the California Statewide Training Education Program (CSTEP) website by clicking [here](#).

**Ensuring
Continuity of
Care**

While other third-party payer programs emerge and Ryan White clients transfer to other programs that they are eligible for, it is critical that Contractors stay aware of their counties' transition plan. Case managers should also document individual transition plan activities in each client chart that details education and support provided through the process of application and enrollment into other payer programs. It is critical that Ryan White staff adequately support a seamless transition and continuity of care and treatment services for transitioning clients.

Note for Contractors in counties that are already screening or preparing to screen their Ryan White clients for LIHP eligibility: It will be necessary for the Ryan White Contractors and service providers to be aware of how their county is screening for LIHP, and know the exact services included in their local LIHP to: 1) estimate how many Ryan White HCP clients will transition to LIHP; and 2) allocate the appropriate amount of funds to other needed service categories that are not covered under LIHP.

Once Ryan White clients are enrolled in LIHP, it is important that service providers update their insurance records in ARIES.

APPENDIX A

TIER I – CORE MEDICAL SERVICES

Outpatient/Ambulatory Medical Care (health services)

Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner, or other health care professional who is certified in his or her LHJ to prescribe antiretroviral (ARV) therapy in an outpatient setting. These settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight.

Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the PHS's guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Note: EIS provided by Ryan White Parts C and D programs are reported under outpatient/ambulatory medical care.

Local AIDS Pharmaceutical Assistance (APA, not ADAP)

Includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. These organizations may or may not provide other services (e.g., outpatient/ambulatory medical care, or case management) to the clients they serve through a Ryan White HIV/AIDS Program contract with their grantee.

Programs are considered APAs if they provide HIV/AIDS medications to clients and meet all of the following criteria:

- Have a client enrollment process;
- Have uniform benefits for all enrolled clients;
- Have a record system for distributed medications; and
- Have a drug distribution system.

Programs are not APAs if they dispense medications in one of the following situations:

- As a result or component of a primary medical visit;
- On an emergency basis (defined as a single occurrence of short duration); or
- By giving vouchers to a client to procure medications.

Note: Local APAs are similar to ADAPs in that they provide medications for the treatment of HIV disease. However, local APAs are not paid for with Part B funds “earmarked” for ADAP.

Oral Health Care

Includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide health care in the State or LHJ, including general dental practitioners, dental specialists, and dental hygienists, as well as licensed and trained and dental assistants.

EIS

Counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, to diagnose the extent of immune deficiency, and to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures. While HIV counseling, testing, and referral services are an integral part of EIS, these services should be reported as aggregate data in the RSR Provider Report. This includes data on individuals with negative confirmatory HIV tests.

Note: EIIHA activities should be reported under EIS and/or Outreach service categories.

**Health Insurance
Premium and Cost
Sharing Assistance**

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles. Under this service category, funds may be used as the payer of last resort to cover the cost of public or private health insurance premiums, including insurance deductible and co-payments.

Important: Grantees should refer to the [HAB Policy Notice-07-05](#), "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance."

**Home Health Care
Services**

The provision of services in the home by licensed health care workers such as nurses, and the administration of intravenous, and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

**Home- and
Community-Base
Services**

Include skilled health services furnished to the individual in the individual's home, based on a written plan of care established by a case management team that includes appropriate health care professionals.

Services include: durable medical equipment, home health aide services, and personal care services in the home, day treatment, or other partial hospitalization services, home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy), routine diagnostics testing administered in the home, and appropriate mental health, developmental, and rehabilitation services.

Note: Inpatient hospitals services, nursing home, and other long-term care facilities are not home and community-based services.

Hospice Services

Include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Funds may be used to pay for hospice care by providers licensed in the state, in which services are delivered. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of six months or less. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid programs.

Mental Health Services

Include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the state (i.e., psychiatrists, psychologists, and licensed clinical social workers).

Note: Mental health services provided to HIV-affected clients should be reported as psychosocial support services.

Medical Nutrition Therapy

Services provided by a licensed registered dietitian outside of a primary care visit and include the provision of nutritional supplements.

Note: Medical nutrition therapy provided by someone considered a support service and recorded under psychosocial support services. A physician recommended nutrition plan should be reported under food bank/home delivery service.

Medical Case Management Services (including treatment adherence)

A range of client-centered services that link clients with health care, psychosocial, and other services provided by trained professionals, including both medically credentialed and other health care staff. The coordination and follow up of medical treatments are a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members' needs and personal support systems.

Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include: 1) initial assessment of service needs; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; 4) client monitoring to assess the efficacy of the plan; and 5) periodic reevaluation and adaptation of the plan, at least every six months, as necessary over the life of the client.

It includes client-specific advocacy and review of utilization of services. This includes all types of case management, including face-to-face, telephone, and any other forms of communication.

Note: Medical case management is provided by dedicated professionals with nursing degrees, masters in social work, health care staff and, in some cases, no degree but the knowledge and life experience can bring.

***Substance Abuse
Services (outpatient)***

Medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.

Such services should be limited to the following:

- Pre-treatment/recovery readiness programs;
- Harm reduction;
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse;
- Outpatient drug-free treatment and counseling;
- Opiate assisted therapy;
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention.

Note: They include limited support of acupuncture services to HIV-positive clients provided the client has received a written referral from his or her primary health care provider and the service is provided by certified or licensed practitioners and/or programs, wherever state certification or licensure exists.

Note: Limited support of acupuncture services to HIV-positive client is allowed only if the client has received a written referral from their primary health care provider and the acupuncture service is provided by a state certified or licensed practitioner or program.

APPENDIX B

TIER II – SUPPORT SERVICES

Case Management (non-medical)

Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services.

Note: Non-medical case management does not involve coordination and follow up of medical treatments.

Child Care Services

The provision of care for the children of clients who are HIV positive while the clients attend medical or other appointments or Ryan White HIV/AIDS Program-related meetings, groups, or training.

Note: This does not include child care while a client is at work.

Emergency Financial Assistance

The provision of one time or intermittent short-term payments to agencies or establishment of voucher programs when other resources are not available to assist with emergency expenses related to essential utilities such as housing, food (including groceries, food vouchers, and food stamps), corrective prescriptive eyewear for eligible clients, and medication only when other resources are not available.

Service providers will need to set priorities, and monitor what part of the overall allocation for emergency assistance is being used for transportation, food, essential utilities, and/or prescription assistance. It is expected that all funds to these purposes will be the payer of last resort, and for limited amounts, limited use and limited periods of time.

Note: Part B Emergency Financial Assistance funds must be allocated, tracked and reported under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

Food Bank/Home-Delivered Meals

Include the provision of actual food or meals, the provision of essential household supplies such as hygiene items and household cleaning supplies should

be included in this item. Food vouchers to purchase food on an ongoing basis should be reported in this service category.

Note: Purchasing food or meals is not allowed under this service category.

Health Education/Risk Reduction

The provision of services that educate HIV-positive clients about HIV transmission, and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Note: Health education/risk reduction services cannot be delivered anonymously; client level data must be reported for every individual that receives this service. Syringe Service Programs and/or Syringe Exchange Programs are no longer Ryan White federally funded.

Housing Services

The provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services, and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Note: Housing funds cannot be in the form of direct cash payments to recipients and cannot be used for mortgage payments. Permanent living situations are not funded under this service category, for permanent housing options refer to Housing Opportunity for People with HIV/AIDS.

Legal Services

The provision of services to individuals with respect to powers of attorney, living will, do-not-resuscitate orders, and 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 Ryan White HIV/AIDS Program; includes the provision of social service counseling or legal counsel.

Note: Legal services may not be used for any criminal defense, or for class-action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program. This does not include any legal services that arrange for guardianship or adoption of children after the death of their caregiver.

Linguistic Services

Include the provision of interpretation (oral) and translation (written) services provided by qualified individuals as a component of HIV service delivery between the provider and client, only when such Services are necessary to support the delivery of Ryan White eligible services.

Medical Transportation Services

Conveyance services provided, directly or through a voucher, to a client so that he or she may access health care services.

Outreach Services

Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status (i.e., case finding), so that they may become aware of, and may be enrolled in care and treatment services.

Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Note: Outreach services do not include HIV counseling and testing or HIV prevention education. Activities such as, providing leaflets at an outside public place or a poster at a bus shelter or tabling at a health fair is not allowable under this service category. EIIHA activities can be reported under this service category and/or EIS.

Psychosocial Services

The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling.

Note: Psychosocial support services include nutrition counseling provided by a non-registered dietitian, but exclude the provision of nutritional supplements.

Referral for Health Care/Supportive Services

The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Note: These services are provided outside of an outpatient/ambulatory medical care, medical case management, or non-medical case management service visit.

Rehabilitation Services

Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Respite Care

The provision of community- or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Substance Abuse Services (residential)

The provision of treatment to address substance abuse issues/needs (including alcohol and/or legal and illegal drugs) in a residential health service setting (short term).

Note: Funds may not be used for inpatient detoxification in a hospital setting.

Treatment Adherence Counseling

The provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Note: This service is provided outside of a medical case management or outpatient/ambulatory medical care visit and clinical setting by non-medical staff.

APPENDIX C

UNALLOWABLE COSTS

Most of the unallowable costs have been addressed in each service category described in Appendix A, however, there are additional unallowable costs for Part B funds, including, but not limited to:

- International travel.
- Construction and renovations to personal or commercial buildings.
- Entertainment costs (i.e., amusement parks, social activities, and related incidental costs).
- Fundraising expenses.
- Lobbying expenses.
- Purchasing clothing.
- Maintenance of privately owned vehicles (i.e., tires, repairs, etc.) and other related payments (i.e., lease, loan insurance, license and registration fees). Note: This restriction does not apply to vehicles operated by organizations for HIV/AIDS-related purposes.
- For funeral, burial, cremation, or related expenses.
- Property taxes (i.e., local or state personal property taxes for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Off-premise recreational activities such as gym membership.
- Payment to attend meetings and conferences such as the National HIV/AIDS Conference.
- Direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

APPENDIX D TRAINING RESOURCES

Depending upon the extent of the role one has working with HIV-positive individuals and services provided, training may be required. To assist Contractors and service providers in providing the highest quality care to the HIV-positive patients in their clinical setting, please click [here](#) to access a list of HIV/AIDS clinical resources. Other training resources include:

California Statewide Training and Education Program (CSTEP)

The Asian and Pacific Islander Wellness Center receives funding from CDPH's OA to implement [CSTEP](#). CSTEP sets the standard in HIV treatment and public benefits education and training for HIV, health and other providers. It helps make that vision a reality by providing a multi-tiered, high-impact training program which is conducted throughout California.

Pacific AIDS Education and Training Center (PAETC)

[PAETC](#) provides HIV clinical education, clinical consultation, capacity building, and technical assistance to health care professionals and agencies in California. PAETC local performance sites offer clinical training programs for health care practitioners with the most current information on the management of HIV-infected patients and interventions to prevent high-risk behavior. Training is adapted to high, medium, or low volume providers. Specific programs based on needs assessments and tailored to specific needs are available. Trainings are customized to a variety of topics related to HIV care, treatment, and prevention.

California STD/ HIV Prevention Training Center (CA PTC)

The [California STD/HIV Prevention Training Center](#) provides a curriculum for medical providers in California free of charge to medical providers and health professionals. The course explains changes in HIV testing as allowed under California Health and Safety Code Section 120990, including the differences between "opt-in" and "opt-out" HIV testing, the pros and cons of traditional and rapid HIV testing and outlines how to integrate routine HIV testing procedures into current practice. Participants also learn how to conduct a brief HIV risk assessment/risk-reduction session, and deliver HIV-negative and HIV-positive test results to patients. The training can be delivered in one-hour modules or as a single four-hour course. For more information, or to schedule training, please click on the [CA PTC website](#).

Warmline

The [National HIV Telephone Consultation Service](#) (Warmline) at (800) 933-3413 provides free and confidential expert consultation on HIV testing and care, including test interpretation (specializing in rapid testing and indeterminate test results). They can also offer guidance for the initial steps in workup and initial management. The Warmline is available 6 a.m. to 5 p.m., Pacific Standard Time, Monday-Friday.