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# HIV COMMUNITY SERVICES

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Concept Paper



APRIL 1, 2016

WASHINGTON STATE DEPARTMENT OF HEALTH  
Office of Infectious Disease

# Concept Paper

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## The Vision

### Introduction

The Washington State Department of Health (DOH) invites community partners to submit applications to develop and implement an HIV Community Services System (HCS) that integrates care and prevention services. DOH will align funding of HIV care services in one or more of the State's Regional Service Areas (RSAs). DOH will fund HIV prevention services that focus on Gay and Bisexual Men (GBM) in Seattle, and secondary urban areas. A full description of these areas will be determined through epidemiological data analysis and released with the RFA in the summer of 2016. Through collaboration with selected applicants, DOH will ensure that consistent high quality HIV care and prevention services are available to Washington residents who need and can benefit from these services.

DOH is the lead state public health agency in Washington. In this role, DOH provides statewide leadership and direction for efforts to prevent and control HIV. We invest state and federal funding in programs and services that both prevent new HIV infections and provide care and treatment to those living with HIV.

### End AIDS Washington

Washington State launched the [End AIDS Washington](http://endaidswashington.org/)<sup>1</sup> campaign on December 1, 2014, World AIDS Day, in support of Governor Jay Inslee's public commitment to ending the HIV epidemic in our state. The campaign calls on state and local governments, community-based organizations, healthcare providers, and others to work together to reduce new HIV infections by 50 percent by the year 2020.

Over the next five years, DOH will work with partners to accomplish the [End AIDS Washington](http://endaidswashington.org/) goal by focusing investments on four main strategies:

- **Getting people insured:** Health insurance coverage connects people to healthcare. With health insurance, people are tested for HIV, get pre-exposure prophylaxis (PrEP), get treatment, and receive many other services important to staying healthy.
- **Getting people tested:** Knowing one's HIV status helps people make informed decisions about their own health and the health of their partners. After getting an HIV test, persons at high-risk for HIV infection (PAHR) can link to PrEP, and persons living with HIV (PLWH) can link to medical care and treatment.
- **Getting at-risk people on HIV PrEP:** PrEP helps PAHR who take PrEP to avoid HIV infection. By using PrEP, people take an active role in keeping themselves HIV negative.
- **Getting HIV-positive people on treatment:** Treatment helps PLWH stay healthy. Treatment also helps PLWH reduce the chances they pass HIV to others.

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<sup>1</sup> <http://endaidswashington.org/>

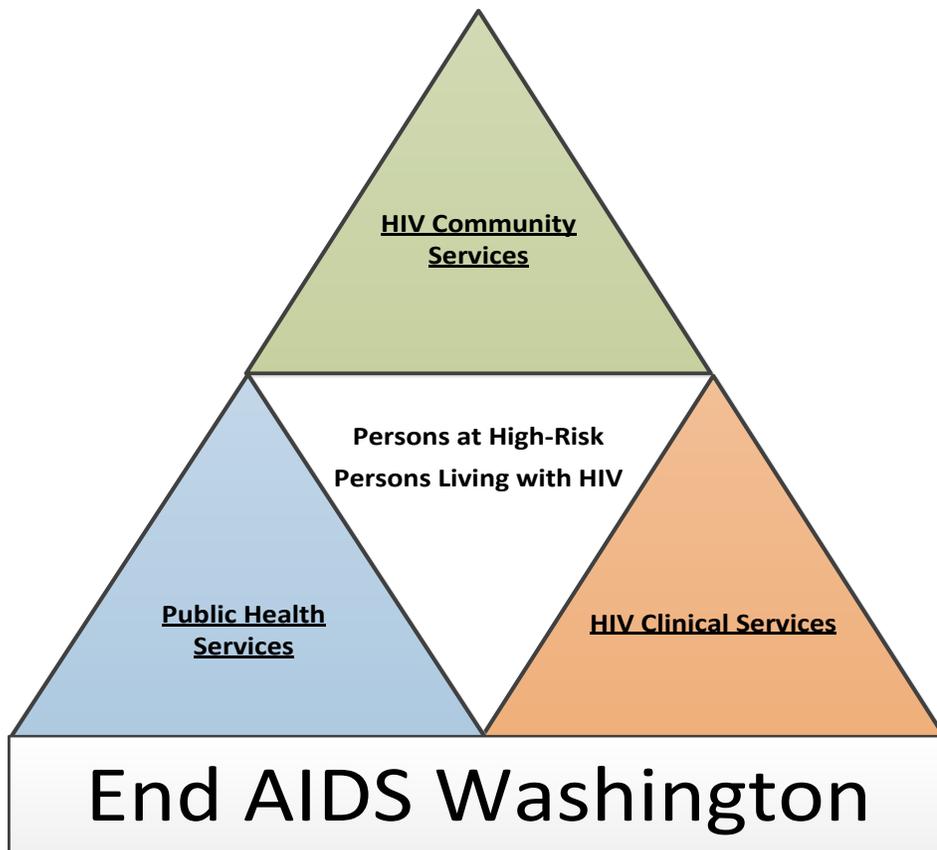
## HIV Prevention, Care and Treatment System

*End AIDS Washington* guides the overall focus of the HIV prevention, care, and treatment system (Illustration 1). This system is composed of three domains:

1. **HIV Community Services** (e.g. population-based services, outreach, HIV testing in nonclinical settings, healthcare navigation and coordination, case management, support services, re-engagement in HIV Community Services, linkages to Public Health and Clinical Services)
2. **Public Health Services** (e.g. surveillance, disease investigation, HIV/STD partner services, re-engagement in HIV care, linkages to HIV Community Services and Clinical Services)
3. **HIV Clinical Services** (e.g. medical care and treatment, Early Intervention Program and other drug assistance programs, health insurance, re-engagement in HIV care, linkages to Public Health and HIV Community Services).

HCS include activities that connect PAHR and PLWH to antiretroviral medications (ARVs) and support services. HCS complement Public Health Services and Clinical Care Services by supporting customers' ongoing engagement and retention in healthcare. Services within the domain of HCS will be included in the Request for Applications (RFA) scheduled for release in summer 2016. Services within the domains of Public Health and Clinical Care will not be included in the HCS RFA. In addition, Syringe Services Programs will not be funded through the HCS RFA.

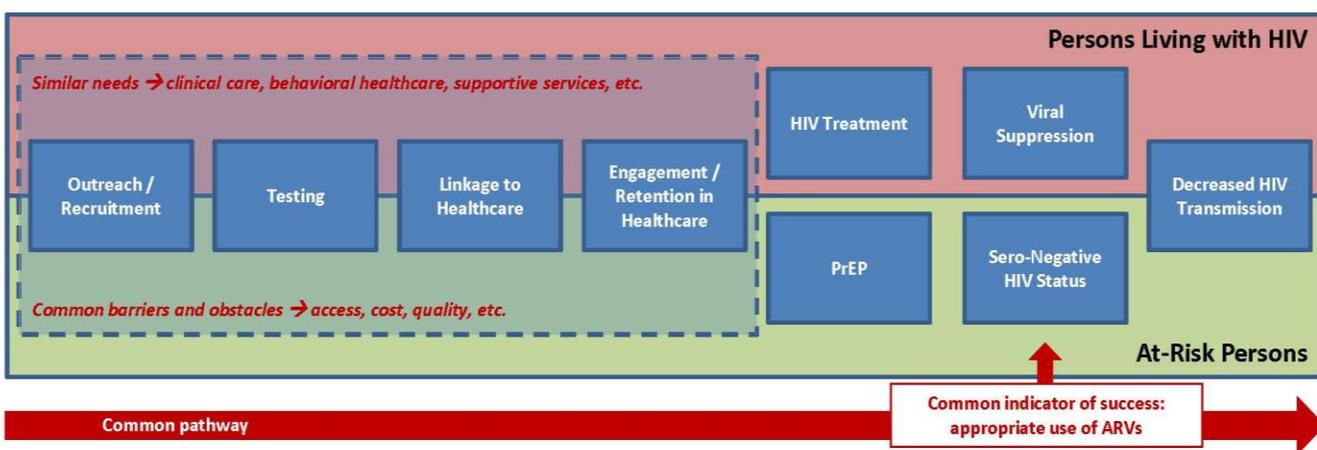
*Illustration 1: The Three Domains: HIV Prevention, Care, and Treatment System*



## Antiretroviral Focus

The HCS model focuses attention on both PrEP and HIV treatment. While PrEP and HIV treatment serve different groups of people, with different aims, individuals who use PrEP and HIV treatment often have similar needs, require similar services, and face common obstacles. Both PrEP and HIV treatment are highly connected to the healthcare system and rely on HCS providers for ongoing support. We use a common indicator to determine success for both PrEP and HIV treatment – appropriate use of ARVs. Illustration 2 – Common ARV Pathway for PrEP, details the common pathway for successful ARV use for PrEP and HIV treatment.

*Illustration 2: Common ARV Pathway for PrEP and HIV Treatment*



In recent years, researchers have found that ARV use can significantly reduce HIV transmission from an infected person to his or her uninfected partner(s). Two primary strategies have emerged from this research: (1) early and sustained treatment for PLWH, also known as treatment-as-prevention, and (2) PrEP for PAHR.

### **Treatment as Prevention**

Treatment-as-prevention is an HIV prevention method that relies on early and sustained treatment of HIV. Treating HIV infection has been the foundation of individual-level HIV care efforts for many years. Successful treatment of HIV has led to dramatic declines in mortality and to improved quality of life.

In 2011, scientists announced that treatment benefits HIV-negative partners of PLWH. Results from a randomized clinical trial demonstrated a 96 percent reduction in transmission when an HIV-positive partner is consistently taking ARVs, which is a monumental finding that has significant benefits for population-level HIV prevention and control efforts.<sup>2</sup>

<sup>2</sup> Cohen, M.S., Chen, Y.Q., McCauley, M., et al. (2011). Prevention of HIV-1 Infection with Early Antiretroviral Therapy. *New England Journal of Medicine*, 365, 493-505. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMoa1105243>.

### **Pre-exposure Prophylaxis**

PrEP is an HIV prevention method in which HIV-negative persons take daily ARV medication to reduce their risk of infection. When used in combination with other prevention tools, such as condoms and clean needles, the level of effectiveness increases.<sup>3</sup> A recent model from San Francisco, a jurisdiction comparable to Seattle, estimates that increased use of PrEP among at-risk individuals can lead to a significant reduction in new HIV infections in the population.<sup>4</sup>

Very few services exist to support PrEP use by at-risk persons in our state. Where they do exist, PrEP services are highly dependent on the local context, including the availability of healthcare providers willing to prescribe and manage PrEP. Most often, local public health programs provide support services only to persons with pre-existing sexually transmitted infections. These programs are often time-limited and do not offer ongoing services for persons who use PrEP. In some areas of our state, no PrEP support services exist.

Unlike HCS for PLWH, which have existed for three decades, HCS for PrEP are new and, as such, lack reach, coordination, and standardization. This means we are not reaching many people who could benefit from PrEP.

### Goals and Outcomes as Guiding Service Principles

HCS covered in this RFA are guided by [End AIDS Washington](#) and the [Washington State Strategic HIV Prevention Framework](#).<sup>5</sup>

The over-arching 2020 goals of [End AIDS Washington](#) are to:

- Reduce by 50% the rate of new HIV diagnoses
- Increase to 80% the percentage of people living with HIV who have a suppressed viral load
- Reduce by 25% the age-adjusted mortality rates among people living with HIV
- Reduce HIV-related health disparities among people living with HIV
- Improved quality of life among people living with HIV

Outcomes from the [Washington State Strategic HIV Prevention Framework](#) are:

- Suppress viral load in all persons living with HIV in Washington State
- Increase use of pre-exposure prophylaxis (PrEP) among gay and bisexual men in Seattle and secondary urban areas
- Decrease incidence of gonorrhea and syphilis among HIV positive persons and gay and bisexual men in Seattle and secondary urban areas
- Increase use of condoms among gay and bisexual men in Seattle and secondary urban areas

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<sup>3</sup> Grant, R.M., Lama, J.R., Anderson, P.L., et al. (2010). Prevention of HIV-1 Infection with Early Antiretroviral Therapy Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men. *New England Journal of Medicine*, 363, 2587-2599. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMoa1011205>.

<sup>4</sup> Grant R.M., Liu, A.A., Hecht, J.J., et al. (2015). Scale-up of Preexposure Prophylaxis in San Francisco to Impact HIV Incidence. *Conference on Retroviruses and Opportunistic Infections*, February 23-26, 2015. Seattle, Washington. Abstract 25. Retrieved at [http://www.natap.org/2015/CROI/croi\\_08.htm](http://www.natap.org/2015/CROI/croi_08.htm).

<sup>5</sup> <http://www.doh.wa.gov/Portals/1/Documents/pubs/430-071-WashingtonStateStrategicHIVPreventionFramework.pdf>

## The Work

### Focus

Funded HIV Community Service programs will focus on a common goal of increasing the use of ARVs to support successful PrEP and HIV treatment. Programs will accomplish this by providing a spectrum of interrelated services:

- Educating communities about PrEP and HIV treatment
- Recruiting individuals into services that support PrEP and HIV treatment
- Ensuring individuals know their HIV status
- Providing support to individuals so they can successfully enroll in health insurance
- Providing support to individuals so they can successfully initiate and sustain healthcare
- Providing support to individuals so they can successfully initiate and sustain ARV for PrEP and HIV treatment

In addition to the above services, agencies may include other support services such as, but not limited to, community-based testing for HIV and sexually transmitted infections, condom distribution, and sexual health education. These complimentary services must actively promote ARVs and will not be funded as stand-alone services.

While ARV use is the priority outcome for HCS, some customers may not choose to utilize them. These individuals can still benefit and should be offered support services other than ARVs.

### Customers

#### Persons At High-Risk for HIV Infection (PAHR)

The Framework defines PAHR customers as gay and bisexual men (GBM) in Seattle and secondary urban areas as defined by epidemiological data. These urban areas contributed 69 percent of new HIV infections from 2006 to 2010. A revised epidemiological profile for Washington State prevention will be released with the RFA in the summer of 2016.

All Washingtonians are affected by the HIV epidemic. However, the HIV epidemic has affected some groups much more than others. Current epidemiological and other data indicate that gay and bisexual men (GBM) of all races and ethnicities bear the greatest burden of HIV disease in Washington State.

Within this population, GBM sub-groups are at increased risk for HIV exposure and transmission, including, but not limited to HIV-negative GBM who have sexual transmitted infections, more than 10 sexual partners in a year, and/or use methamphetamine or poppers. Similarly, racial, and ethnic GBM sub-groups experience disproportionate rates of infection. Accordingly, activities to promote ARV use for PrEP will primarily target GBM with a special focus on sub-populations.

***DOH will fund HCS for PAHR with a focus on services for Gay and Bisexual Men (GBM) in Seattle, and secondary urban areas. A full description of these areas will be determined through epidemiological data analysis and released with the RFA in the summer of 2016.***

***DOH will fund HCS for PAHR with an emphasis on GBM sub-groups that are at increased risk for HIV and/or belong to racial or ethnic sub-groups that experience disproportionate rates of HIV infection.***

***HCS will emphasize and employ creative solutions to address health disparities among PAHR customers.***

#### Persons Living with HIV (PLWH)

The Framework defines PLWH customers from a statewide perspective. DOH will align funding for HCS for PLWH with the Washington State Health Care Authority (HCA) designated Regional Service Areas (RSAs) (see map in Appendix 1).

Our state has a long history of providing high-quality services that help PLWH stay engaged in care. Currently, these services only reach 43 percent of HIV-positive persons in Washington State. DOH's objective is to expand services so that HCS reach 80 percent of HIV-positive persons. When customers receive services, the majority achieve viral suppression.

In 2014, we estimate that 14,100 people were living with HIV in Washington. Of these individuals, 10,100 (72 percent) were engaged in care during the previous 12 months, and 8,600 (61 percent) had reached viral suppression. This means that roughly 40 percent of PLWH were not successfully utilizing ARVs for HIV treatment. Efforts to promote ARV use as HIV treatment will be targeted to all PLWH.

***DOH will align HCS funding for PLWH with HCA designated RSAs.***

#### Persons At-Risk for HIV Infection and Persons Living with HIV

Many PAHR and PLWH have co-occurring conditions such as heart disease, depression or other mental health problems, or drug or alcohol addiction. Poverty, unemployment, domestic violence, homelessness, hunger, lack of access to transportation, and other issues can prevent people from accessing healthcare. HCA developed Accountable Communities of Health (ACHs) to address many of these issues. By coordinating HCS with ACHs, we connect with partners who are actively strategizing ways to improve healthcare, reducing healthcare costs and leading to improved healthcare for our customers. This has the potential to help us identify additional resources to support HCS customers.

***HCS providers will need to actively engage with their respective ACHs to identify collaborations and opportunities, to reduce redundancies, and to leverage healthcare systems and other payer resources to best meet the needs of their customers and to ensure that HCS resources are used as a last resort.***

#### Health Disparities

The HIV epidemic has affected some groups more than others in Washington State. Overall, gay and bisexual men of all races and ethnicities, compared to heterosexual men, experience a disparity for HIV infection with certain sub-groups experiencing disproportionate rates of infection. US born black residents, foreign-born black residents, foreign-born Hispanics, and younger adults (18-35) all experience HIV-related health disparities across the care continuum. Despite improvements in reducing

the rate of new diagnoses, linking and retaining HIV-positive individuals in care and achieving viral suppression among the overall population, persistent disparities remain for some groups in our state. Addressing and reducing these disparities is a moral imperative and is essential to the success of *End AIDS Washington*. [For more information about HIV-related health disparities in Washington, please see [HIV-Related Health Disparities 2015](#).]<sup>6</sup>

For PAHR, it is important that prevention tools such as PrEP are reaching communities and individuals that can benefit, with special emphasis on Black and Latino GBM. PrEP DAP data illustrates that of the 500 PrEP DAP enrollees, only two percent are Black while Black Washingtonians represent 18 percent of all new HIV diagnoses. Accordingly, activities to promote ARV use for PrEP should be primarily targeted to GBM with a special focus on sub-populations that experience disparities. To achieve an end to the HIV epidemic in Washington, we must transition our system to one that appropriately serves PAHR.

Black PLWH born in the United States (U.S.) and Hispanic PLWH born outside the U.S. are less likely to link to and engage in HIV-related medical care and are less likely to show viral suppression, when compared to White PLWH. PLWH who live in areas with moderately high levels of income and education are often the least likely to be engaged or retained in HIV medical care, despite socioeconomic advantage. To achieve an end to the HIV epidemic in Washington, we must transition our system to one that appropriately serves the *entire* population of PLWH.

***HCS will emphasize and employ creative solutions to address health disparities among PAHR and PLWH customers.***

## Funded Services

DOH will fund the following activities as part of HCS RFA (see Appendix 2: Service Definitions).

### **Population Based Services (PLWH, PAHR)**

- Community-level strategies to understand and identify population needs
- Community-level strategies to engage, mobilize, and empower communities to seek healthcare services including health insurance, HIV testing, PrEP, and HIV treatment
- Drive new customers to HCS individual based services

### **Individual Based Services**

- Outreach Services (PLWH, PAHR)
  - Identification of people who do not know their HIV status and linkage into HIV Community Services
  - Provision of additional information and education on health care coverage options
  - Re-engagement of people who know their status into HIV Community Services

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<sup>6</sup> <http://www.doh.wa.gov/Portals/1/Documents/Pubs/150-071-HIVHealthDisparitiesSEWReportMar2015.pdf>

- Note: outreach services must be bundled with a direct service like testing, health care navigation, insurance navigation, etc. Outreach will not be funded as a stand-alone service.
- HIV & STD Testing in Nonclinical Settings (PLWH, PAHR)
  - Targeted HIV & STD testing in nonclinical settings of people who do not know their status
  - If found to be HIV positive:
    - Report status to Public Health
    - Linkage to HIV care and treatment
    - Linkage to partner services
    - Health Education / Risk Reduction
    - Treatment as prevention
    - PrEP for partner(s)
  - If found positive for STDs:
    - Linkage to clinical provider for treatment
    - Linkage to partner services
  - If found to be HIV negative:
    - Linkage to PrEP as appropriate
    - Health Education / Risk Reduction
- Healthcare Navigation & Coordination (PLWH, PAHR)
  - Education on health care coverage options (e.g. qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
  - Access and linkage to care and treatment services, including, but not limited to, case management, HIV clinical services, Public Health services, and other support services
  - Referral services to improve care and treatment services at key points of entry
  - Health literacy
- Case Management (PLWH, PAHR)
  - Customer centered activities focused on improving health outcomes
  - Benefits counseling to assist HIV positive and PrEP customers obtain access to other public and private programs for which they may be eligible (e.g. Medicaid, Medicare Part D, EIP/ADAP, EHIP, health care and supportive services, and insurance plans through the health Insurance Marketplace/Exchanges)
  - Ensuring readiness for ARVs for PrEP or HIV treatment
  - Treatment adherence support for ARVs for PLWH and PrEP for PAHR
- Support Services (PLWH, PAHR)
  - PLWH and PAHR: Health Education / Risk Reduction, Psychosocial Support Services
  - PLWH: Payment of support services for PLWH includes Early Intervention Services (EIS), Food Bank/Home Delivered Meals, Housing Services, Linguistic Services, Medical Nutrition Therapy, Medical Transportation, Mental Health Services, and Substance Abuse Services Outpatient Care.
  - PAHR: Many support services are not funded through HCS. HCS service providers should link PAHR customers to community resources based on need.

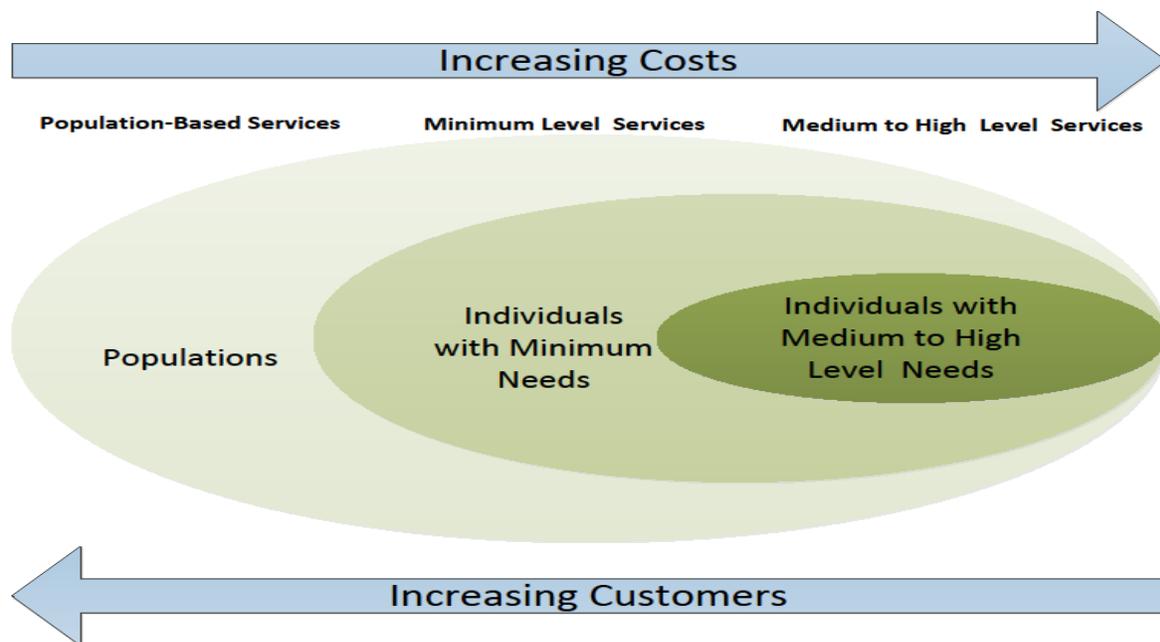
- Re-Engagement in HCS (PLWH, PAHR)
  - Re-engagement of PLWH or PAHR on PrEP into clinical care or case management services.

### Service Levels

Given the expanded customer-base generated by integrating HIV prevention and care services, agencies will provide a larger array of services along the spectrum of needs to serve customers at the different stages in their lives. The HCS system will offer services that have not been available to PLWH and PAHR customers before, specifically services that are lower threshold, such as easy access to health insurance enrollment and/or linkages to culturally competent healthcare providers for PAHR. It will take time to raise the profile of the new HCS system and DOH will work closely with future funded providers to achieve this aim (see Appendix 3: Service Levels).

DOH has established three service levels, which provide support to PAHR and PLWH depending on individual needs. These levels (population-based, individual-minimum, and individual-medium to high level services) create a flexible array of services that will meet the needs of PAHR and PLWH. Future funded programs will also have flexibility to move customers across levels as life circumstances change. These three levels of service have not been formalized at this time. Instead, DOH will ask programs to work with us to define the characteristics of persons who are best served by each level.

*Illustration 3: Service Levels*



### Population-Based Services

Population based services focus on the overall customer populations served, define overarching population health needs, and empower communities to better understand and use healthcare and ARVs for PrEP and treatment. To achieve the goals of [End AIDS Washington](#) the scale of HIV prevention, care, and treatment services needs to be amplified to reach more customers. Population-based services will

be a driver of new customers to the HCS system. These services will be the primary mechanism to expand knowledge, awareness, and, ultimately, use of health insurance, healthcare, PrEP, and HIV treatment. Population-based services will help ensure that large segments of targeted communities are aware that the support and help are available and know where and how to access it.

#### Minimum Level Support Services

Minimum level support services focus on individuals within customer populations who need a minimum level of support to stay engaged in healthcare and on ARVs, including people who need help initiating or sustaining ARVs for PrEP and HIV treatment.

#### Medium to High Level Support Services

Medium to high level support services focus on individuals who need high-intensity support, such as individuals with co-occurring mental health conditions or substance use disorders, persons who are homeless or marginally housed, and persons who are geographically isolated.

#### Acuity Model

DOH has adopted an Acuity Model with the aim of providing services that are customer-appropriate, supportive of independence and self-sufficiency, and promote responsible utilization of resources. The Acuity Model is an engagement and retention in care process that applies to PAHR and PLWH. It requires the consent and active participation of the customer in decision-making. It supports a customer's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality services. The Acuity Model informs the service provider of the appropriate service level and services for each customer. The Acuity Model concept is based on the HIV Care Acuity Model. A PAHR Acuity Model will be developed with input from the community and service providers to meet the needs of HCS customers and programs.

***HCS proposals will need to integrate a variety of services along a spectrum to provide services based on customer need as determined by Acuity Model.***

#### Workforce

With our commitment to serve more people, provide the right services, and reduce costs, HCS needs a workforce that meets new demands.

#### Population Based Services

The workforce that provides population-based services will focus on recruiting new customers. They must be skilled at helping communities identify and understand their health needs and healthcare options and engaging, mobilizing, and empowering communities to seek healthcare services, including health insurance, HIV testing, PrEP, and HIV treatment. Examples of work activities/skills:

- Helping communities identify and understand their health needs and healthcare options
- Engaging, mobilizing, and empowering communities to seek health insurance and healthcare services, including HIV testing, PrEP, and HIV treatment

- Helping individuals access health insurance and healthcare marketplaces
- Providing advocacy and other support
- Addressing health disparities and stigma

#### Minimum Level Support Services

The workforce that provides minimum services will work with customers who have minimum level needs. They must be skilled at providing basic care navigation and coordination and recognizing when a customer needs to be referred to or linked to higher level services. Examples of work activity/skills:

- Helping PAHR and PLWH enter the healthcare system
- Helping customers navigate, apply for, and use third party payer systems such as insurance, Medicaid, and Medicare
- Helping individuals successfully link to and utilize healthcare services, including PrEP and HIV treatment.
- Helping customers identify additional needs and linking them to support services
- Addressing health disparities and stigma

#### Medium to High Level Support Services

In addition to providing minimum level services, the workforce that provides medium to high-level services will concentrate on customers with the most complex needs. This workforce needs greater expertise to help customers engage with more complicated healthcare services, while at the same time addressing co-occurring conditions. Examples of work activity/skills:

- Providing linkages for co-occurring conditions, such as mental illness, substance use disorders, homelessness, and geographic isolation
- Offering ongoing support to keep people engaged and retained in care so they can be successful on PrEP and HIV treatment.
- Addressing health disparities and stigma

***HCS will be looking for proposals that include the workforce capacity necessary to provide a range of services along a continuum of care services***

#### Active Recruitment of New Customers

To reach more customers, we need to scale up our HIV prevention, care, and treatment response. Services available through the Ryan White Program have been effective in meeting the needs of PLWH, but these services only reach 43 percent of HIV-positive persons in Washington State. DOH's objective is to expand services so that HCS reach 80 percent of HIV-positive persons. For PAHR, there are significant opportunities to expand the reach of PrEP and HIV prevention support services.

Population-based services will be a primary driver of new customers to the enhanced community services system. These services will be the primary mechanism to expand knowledge, awareness, and, ultimately, use of health insurance, healthcare, PrEP, and HIV treatment. Future funded partners will be asked to actively engage communities in order to better understand community needs, norms, values, and interests.

To expand the number of people who use ARVs for PrEP and HIV treatment, agencies need to recruit more individuals into their programs along with raising awareness in these populations through population-based services.

Agencies should:

- Work collaboratively with other agencies through ACHs to assess the needs, strengths, and assets of PAHR and PLWH in their communities
- Create proactive strategies to reach and recruit people into services
- Develop coordinated action plans for providing and evaluating services that promote successful ARV use
- Identify and reduce redundancies

### Reduction of Redundancy and Achievement of Economies of Scale

By serving both PAHR and PLWH, DOH reduces the costs of maintaining separate systems of prevention and care, including separate workforces with similar skills. With an increased focus on low and moderate-level services that typically cost less, we are able to serve more people with routine needs, freeing up higher skilled workers to focus on individuals with more complex needs.

***HCS will ask funded partners to actively engage communities to better understand community needs, norms, values, and interests, and to provide services that will motivate and empower individuals to take an active role in their health by enrolling health insurance, seeking and using healthcare, and using ARVs for PrEP or HIV treatment.***

### Alignment of Services with Complementary Systems

Effective collaborations are essential to expanding service delivery in support of increased ARV use among PAHR and PLWH. To meet the increasing demands of our HCS, we must strengthen partnerships with traditional partners, including Public Health and Clinical Care, and establish new partnerships with organizations leading work to transform healthcare in our state.

Washington State received funding from the Center for Medicare and Medicaid Innovation to support Healthier Washington. The Healthier Washington project builds the capacity to move health care purchasing from volume to value, improve the health of state residents and deliver coordinated whole person care. In support of this goal, The Washington State Health Care Authority (HCA) and the Department of Social and Health Services established Regional Service Areas (RSAs) for Medicaid purchasing, specifically for the integration of coverage for physical and behavioral healthcare. As the driver of health system transformation within each of the RSAs, the HCA developed Accountable Communities of Health (ACHs). ACHs will bring together diverse sectors of regional public and private entities to consider and reflect specific characteristics and needs within their RSAs and communities.

Many HCS customers are eligible for Medicaid coverage, so it is critical to understand and, where possible, influence upcoming payment reform. By aligning our programs with these ongoing efforts, we

position our programs to better serve our customers and reduce costs. To this end, HCS for PLWH will be funded based on RSA regions (see Healthier Washington).<sup>7</sup>

***HCS providers will need to actively engage with their respective ACHs to identify collaborations and opportunities, to reduce redundancies, and to leverage healthcare systems and other payer resources to best meet the needs of their customers and to ensure that HCS resources are used as a last resort.***

***HCS for PLWH must align with established RSAs.***

## Measuring Success

To ensure that DOH meets the goals of the HCS, outcomes of the programs it supports will be included in performance-based contracts.

During the inception phase of the program, DOH will measure success in establishing the system, baseline measurements, and reporting requirements. DOH will negotiate performance objectives with community service providers throughout the initial implementation of the project and in successive contract periods. DOH will establish baseline levels at the start of the contract period (within the first three months). DOH will identify targeted performance levels in coordination with the service provider.

## The Providers

### Eligible Bidders

Eligible bidders include non-profit community health centers, Federally Qualified Health Centers, community based service organizations, AIDS service organizations, public health agencies, and for-profit health care organizations. Funds issued as a result of this application process are funds of last resort. Successful bidders must leverage other available resources, including third party payers when possible, to demonstrate compliance with this requirement.

For PLWH, DOH will fund services based on joint HCA / DSHS Designation of Regional Service Areas for 2016 Medicaid Purchasing.<sup>8</sup>

For PAHR, DOH will fund services that focus on Gay and Bisexual Men (GBM) in Seattle, and secondary urban areas. A full description of these areas will be determined through epidemiological data analysis and released with the RFA in the summer of 2016.

All agencies funded as a result of the application will be expected to engage with their respective ACHs to best meet the needs of HCS customers.

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<sup>7</sup> <http://www.hca.wa.gov/hw/Pages/default.aspx>

<sup>8</sup> <http://www.hca.wa.gov/releases/rsa%20announcement%2011-04-14.pdf>

DOH expects agencies funded as a result of this application to collaborate closely with DOH to ensure consistent quality and overall coordination of HCS. DOH expects funded agencies to follow established standards of care.

Applicants must be licensed or capable of becoming licensed to do business in the state of Washington and demonstrate achievement of the following criteria:

### **Internal Capacity**

- 1) Applicants must demonstrate:
  - a. Experience and proficiency in serving PAHR and PLWH
  - b. Experience collecting and reporting on quality assurance data, fiscal monitoring reports, CDC/HIV/AIDS Bureau (HAB) measures, or other performance indicators;
  - c. The ability to commence services on January 1, 2017;
  - d. The ability to engage the three service domains (HCS, Public Health Services, Clinical Care) to deliver services;
  - e. The ability to provide PLWH services that align with designated RSAs; and/or the ability to provide PAHR services that focus on Gay and Bisexual Men (GBM) in Seattle, and secondary urban areas. A full description of these areas will be determined through epidemiological data analysis and released with the RFA in the summer of 2016.
  - f. Ability to use an acuity based system to provide an appropriate level of service to meet customer need;
  - g. For agencies providing PLWH case management, have a signed contract with the Department of Social and Health Services to provide Title XIX case management and follow Washington HIV Case Management Standards of Care.
- 2) Applicants must be fiscally sound and administratively efficient and effective.
  - a. Able to pass a financial risk assessment conducted by DOH (see Appendix 4);
  - b. Able to demonstrate capacity for project management and leadership, to include detailed planning, reporting, program implementation, and evaluation.
- 3) Applicants must demonstrate the capacity to use the Statewide CAREWare Data Base to track PLWH and a yet to be determined Statewide database to manage PAHR<sup>9</sup> demographics and services, including:
  - a. Directly entering customer level data into the Statewide Data Bases;
  - b. Use Statewide Data Bases for progress notes and case notes;
  - c. Use Statewide Data Bases to track services provided;
  - d. Use Statewide Data Bases to report encounter data, such as medical visits, viral load and CD4 laboratory results (PLWH), and other data as agreed upon;
  - e. Use Statewide Data Bases to track screenings, testing, or other information as deemed necessary to meet desired outcomes.

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<sup>9</sup> Data Bases for PAHR will be developed with input from the community and service providers to meet the needs of HCS customers and programs.

- 4) Applicants must demonstrate the capacity to participate in a quality management program, including:
  - a. DOH program and fiscal monitoring activities;
  - b. Quality assurance activities;
  - c. Quality improvement activities;
  - d. Accountability to funders;
  - e. A method for using customer input to guide service quality improvement;
  - f. Active participation in DOH program implementation and evaluation processes;
  - g. Follow DOH service standards.
- 5) Applicants must demonstrate a commitment and feasible plan to implement comprehensive sustainable services consistent with the chronic care health care model (e.g. Health Homes, Care Coordination, and integration with private and public healthcare payers).

### **External Capacity**

- 1) Applicants for the RFA will need to demonstrate substantive collaboration for provision of HIV continuum services, which includes evidence of:
  - a. Formal partnerships, networks, and/or coalitions that will work together to address population and individual level health outcomes related to HIV;
  - b. Accountability mechanisms for collaborative work (e.g. memoranda of understanding work plans)
  - c. Collaborations that include participation from community service providers, public health agencies, and HIV medical providers.
- 2) Applicants will need to demonstrate a capacity to achieve policy and system changes and quality improvements at a system level or a plan to gain this capacity with DOH-provided technical assistance.
- 3) Applicants will need to use evidence-based or best practices and specific interventions to reach HIV-positive and high-risk HIV-negative persons in the service area and address the following:
  - a. Engaging PLWH and PAHR in care and treatment services;
  - b. Retaining PLWH and persons receiving PrEP persons in care and treatment services;
  - c. Re-engagement of PLWH and persons receiving PrEP in care and treatment services whose care is irregular or interrupted;
  - d. Provision of treatment adherence support services for PLWH and PAHR receiving PrEP.
- 4) Applicants should refer to their Washington State HIV Services Plan for relevant data to assist with understanding the context and aims of this project.
- 5) Applicants will need to meet payer of last resort policy that states HSC funds cannot be used to make payments for any item or service for which payment has been made or can reasonably be expected to be made by a third party payer, including private insurance, Medicaid, Medicare, or other federal, state, or local health benefits or entitlement programs.
- 6) Applicants will be expected to use Washington State Department of Health HIV epidemiologic and surveillance data, Washington State Ryan White program data, Washington State Healthcare Authority data, and Washington State Department of Social and Health Services data to characterize

eligible populations, resources, and service gaps in their proposed service areas. Other acceptable sources of data for the demographic characteristics of proposed service areas include US Census data should be used to describe the general demographic characteristics of the proposed service area{s}. Regional profiles with a basic set of epidemiological and demographic characteristics for each region are available from DOH.

Applicants are encouraged to use material available from the Centers for Disease Control and Prevention (CDC) and the U.S. Health Resources and Services Administration (HRSA) and publicly available peer-reviewed research to support their proposed service model. Applicants will need to provide the source of information used to support their proposals.

### Formalized Collaborations

To achieve the goals of *End AIDS Washington* coordination and collaboration among local and state HIV service organizations and care service providers, including HIV clinical care providers must be enhanced. Applicants will need to describe how they will ensure that the full range of HCS will be available in their service area either directly provided by applicants, or through formal collaborations. Applicants will need to include letters of commitment or memoranda of agreement from collaborating entities with their application.

### Service Agreements and Memoranda of Agreement/Understanding (MOAs/MOUs)

Applicants will be required to demonstrate how they will use existing partnerships and establish new formalized collaborative partnerships as needed to achieve the outcomes described in this application. Applicants will need to include detailed service agreements with key community partners, including public health agencies, HIV medical care providers and essential social support service providers (housing, substance abuse counseling and services, mental health services, schools, etc.) to show how they will maximize the reach and effectiveness of HCS in the proposed service area.

Applicants will need to have at least one established service agreement with an HIV medical care provider in the proposed service area (internal and/or external to the applicant organization) at the time the application is submitted. When establishing a service agreement with an HIV medical care provider, applicants should consider the following:

1. Location of medical and other service providers within the applicant organization's service area.
2. The collaborating organizations' capacities and history serving PLWH and people at risk of HIV infection.
3. HCS that may be accessed via referrals in, or in proximity to, the proposed service area. Service agreements must include, at a minimum:
  - Name and address of the provider(s).
  - Name, title, and contact information (i.e., primary work address, email, and phone number) for the primary point of contact for medical care providers.

- For collaborations with public health departments and medical care providers, a description of procedures that will be used to link newly diagnosed PLWH and previously diagnosed PLWH who are out of care to medical care within 90 days, including:
  - a. The responsible party for scheduling medical appointments.
  - b. Confirming the individual’s attendance at the first medical appointment with a provider qualified to prescribe and monitor treatment with anti-retroviral therapy (ARV).
  - c. Ensuring enrollment in comprehensive engagement and retention in HIV medical services provided by the applicant.
  - d. Ensuring ongoing collaboration between partners to support open-ended provision of HIV engagement and retention in care services.
- Signatures from the Business Official for the applicant organization, public health agency, and/or the HIV medical care provider.

## The Proposals

### Required Elements

DOH based the framework underlying HCS on well-established public health practices and principles. It aims to reduce HIV-related morbidity, mortality, and related health disparities among racial and ethnic minorities in Washington State by integrating HIV prevention and care strategies and resources. DOH expects its community partners to provide evidence based services that will both improve the lives of PLWH and reduce the population impact of the HIV epidemic, as envisioned by *End AIDS Washington*.

Applicant organizations will be required to provide comprehensive HIV care and prevention services for PLWH and PAHR. To qualify for contracts, agencies must demonstrate they are able to establish a program that includes:

- HIV care services using DOH’s Acuity Model Framework
- Referral networks and formalized collaborations that will support the proposed services
- Program promotion, outreach, and recruitment strategies
- HIV testing component
- Essential services for PLWH, including:
  - Access to adequate and affordable health insurance
  - Engagement in HIV-related medical care
  - Linkage to partner services
  - ARV promotion and initiation
  - Adherence to ARV and other prescribed medical care
  - Plan for third party reimbursement and leveraging generic health care resources
  - Support services for PLWH based on need
- Essential services for PAHR, including:
  - Access to adequate health insurance
  - Engagement in medical care
  - PrEP promotion, education and assessment

- Linkage to qualified PrEP providers
- Adherence support for people who initiate PrEP
- Plan for third party reimbursement and leveraging generic health care resources
- Linkages to support services for PAHR based on need
- Organizational capacity, including
  - Service improvement through feedback from persons served
  - Capacity and plan to use service data for quality improvement and continuous quality improvement
  - Capacity and plan to report essential system performance data to DOH
  - Capacity for financial management, including internal controls and audit procedures
- Ability to provide services in designated service areas
  - Services for PLWH in one or more of the State's Regional Service Areas (RSAs)
  - Services for PAHR that focus on Gay and Bisexual Men (GBM) in Seattle, and secondary urban areas. A full description of these areas will be determined through epidemiological data analysis and released with the RFA in the summer of 2016.

## Conclusion

To achieve the goals set by *End AIDS Washington*, we must have robust HCS. We depend on these services to get people insured, get them tested, and get them connected to healthcare so they can successfully use PrEP or HIV treatment. We believe a combination of high-quality HCS, Public Health Services, and Clinical Care Services creates the momentum necessary to reduce new infections in our state, while working to optimize health outcomes for the people we serve.

*End AIDS Washington* sets a goal of reducing new HIV infections by 50 percent by the year 2020. While ambitious, we believe we have the tools necessary to accomplish this goal, including ARVs for PrEP and HIV treatment, both of which prevent HIV transmission. We are at a critical turning point in the HIV epidemic in Washington State. Rates of new HIV and AIDS diagnoses, as well as the mortality among PLWH, have been gradually declining in Washington State over the last decade. This success is a product of scientific advances that have made HIV a treatable condition, and the effectiveness of our state's prevention, care and treatment infrastructure. Public investments and collaborations among PLWH, HIV advocates, community-based organizations, government, and healthcare and social service providers have put Washington at the forefront of HIV treatment and prevention efforts.

By serving both PAHR and PLWH in HCS, DOH reduces the costs of maintaining separate systems of prevention and care, including separate workforces with similar skills. With an increased focus on moderate-level services that typically cost less, we are able to serve more people with routine needs, freeing up higher skilled workers to focus on individuals with more complex needs. By aligning HCS for PLWH within RSAs through the ACHs, we connect with partners who are actively strategizing ways to improve healthcare, while at the same time reducing healthcare costs. This has the potential to help us identify alternative funding to support our services, as does having services paid for by health insurance, whenever possible.

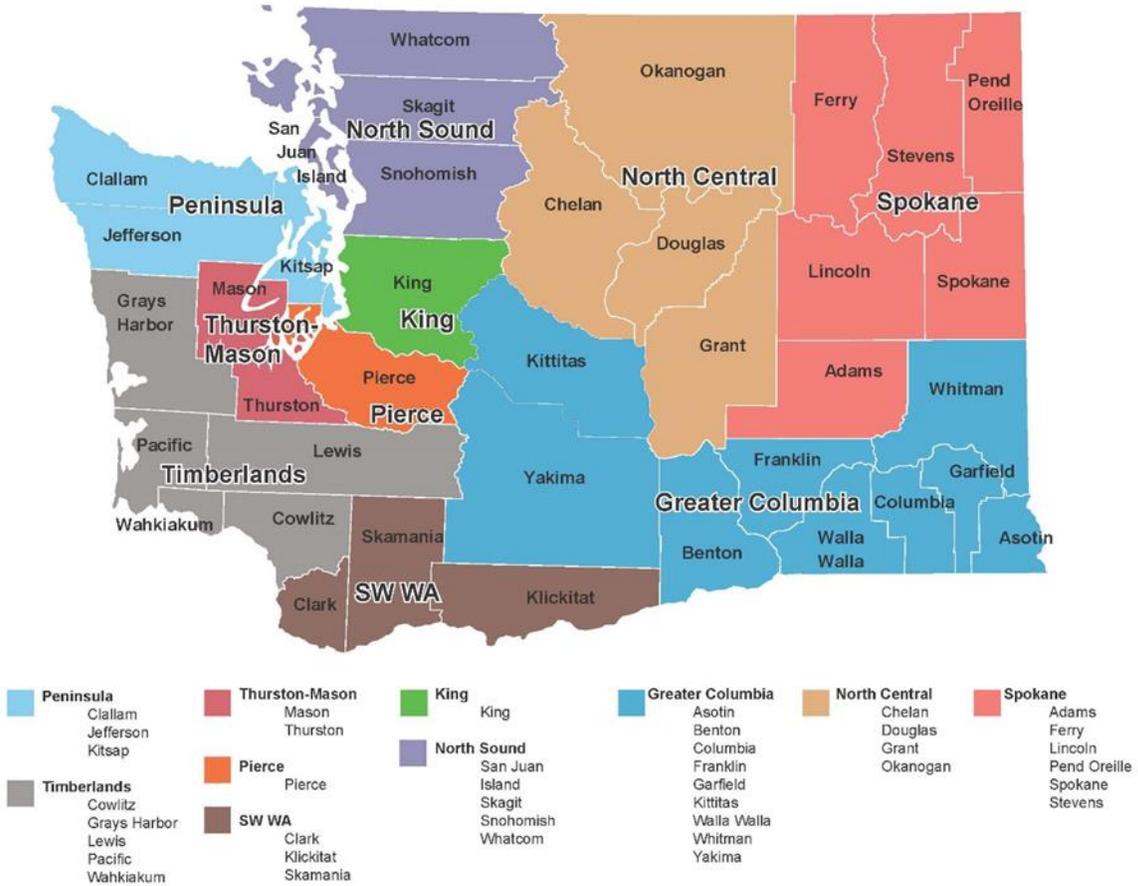
To use these tools effectively, we must enhance our state's HCS to expand capacity and infrastructure. We will broaden the array of services we provide and extend the reach of these services to more people who can benefit. We will organize our workforce to meet the increasing demand for lower intensity services, while preserving our unique capacity to provide services for people with complex needs. We will strengthen relationships with our traditional partners and strive to develop new partnerships with entities working to transform healthcare in our state.

We have an unprecedented opportunity to turn the tide on the HIV epidemic in Washington State. We are confident HCS will be a powerful force that helps us achieve the National HIV/AIDS Strategy vision, where Washington State, "...will become a place where new HIV infections are rare and when they do occur, every person...will have unfettered access to high-quality, life extending care".

## APPENDICES

# Appendix 1: Service Area Maps

## HCS for PLWH - Regional Service Areas



## Appendix 2: Service Definitions

The Ryan White HIV/AIDS Program legislation defines funding for PLWH using HRSA funding.<sup>10</sup> Not all services available for PLWH are funded for PAHR. Non-DOH funding should be coordinated to expand the services available for PAHR.

### **Acuity Model**

The Acuity Model is an engagement and retention in care process that applies to PAHR and PLWH. It requires the consent and active participation of the customer in decision-making. It supports a customer's right to privacy, confidentiality, self-determination, dignity and respect, nondiscrimination, compassionate non-judgmental care, a culturally competent provider, and quality services. The Acuity Model informs the service provider the appropriate service level and services for each customer. The Acuity Model concept is based on the HIV Care Acuity Model.

#### Program Guidance – PAHR

A PAHR Acuity Model will be developed with input from the community and service providers to meet the needs of HCS customers and programs.

### **Condom Distribution**

Condom distribution ensures that condoms are available, accessible, and acceptable to PLWH and PAHR across Washington State. It includes ensuring that condoms are available in the environments where members of the target population are found, such as pharmacies, condom dispensing machines, and outreach workers and ensuring unrestricted access to condoms that are available in the environment by providing free condoms that are conveniently located in multiple locations. Distribution programs should be integrated into other service activities that promote condom use and other risk reduction behaviors.

#### Program Guidance – PAHR, PLWH:

Condom distribution for PLWH and PAHR must be bundled with a direct service including, but not limited to, HIV testing, Health Education/Risk-Reduction activities, healthcare navigation/coordination, and insurance enrollment/navigation. Condom distribution will not be funded as a stand-alone activity.

### **Early Intervention Services (EIS) (PLWH)**

Early Intervention Services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected.
  - Agencies must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources

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<sup>10</sup> Ryan White Legislation - Section 2651 (e) of the Public Health Service ACT

- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as Medical Case Management, Outpatient/Ambulatory Health Services, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

Program Guidance:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. Agencies should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

**Food Bank/Home Delivered Meals**

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 essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance - PAHR:

This service is not funded through HCS. HSC service providers should link PAHR customers to community resources based on need.

Program Guidance - PLWH:

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

**Health Education/Risk-Reduction**

Health Education/Risk Reduction is the provision of education to PLWH and PAHR customers about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with customers to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for customers' partners and treatment as prevention (PLWH)
- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for PAHR
- Education on health care coverage options (e.g. qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education
- Condom access

Program Guidance - PAHR:

This service is not fundable as a stand-alone category. Agencies cannot provide Health Education/Risk Reduction services anonymously.

Program Guidance - PLWH:

Agencies cannot provide Health Education/Risk Reduction services anonymously.

**Healthcare Navigation & Coordination**

Healthcare navigation and coordination are service delivery processes to help PLWH and PAHR obtain timely, essential and appropriate medical and social services to optimize health outcomes through engagement with healthcare systems. Healthcare Navigation includes linking persons to health care systems, assisting with health insurance and transportation, identifying and reducing barriers to care, and tailoring health education to the client to influence his or her health-related attitudes and behaviors. Healthcare Coordination ensures customers, particularly customers with complex healthcare needs, get the right care at the right time in the right settings while avoiding unnecessary duplication of services.

Program Guidance - PAHR, PLWH:

This service will allow service providers to link PAHR and PLWH customers to resources not funded by HCS.

**Housing Services**

Housing services provided limited short-term assistance to support emergency, temporary, or transitional housing to enable a customers or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a customers or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the customers or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential care, assisted living residential services). It can also include housing that does not provide direct medical or supportive services, but is essential for a customers or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Program Guidance - PAHR:

This service is not funded through HCS. HSC service providers should link PAHR customers to community resources based on need.

#### Program Guidance - PLWH:

Recipients must have mechanisms in place to allow newly identified customers access to housing services. Upon request, recipients must provide the Department with an individualized written housing plan, consisting with HRSA Housing Policy 11-01<sup>11</sup>, covering each customer receiving short term, transitional, and emergency services. Recipients and local decision planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. The US Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months. The Department recommends that recipients consider using HUD's definition as their standard.

Housing services funds cannot be in the form of direct cash payments to customers. Housing services funds cannot go towards mortgage payments.

#### **HIV and STD Testing in Nonclinical Settings**

HIV and STD testing in nonclinical settings include testing services at sites where medical, diagnostic, and/or treatment services are not *routinely* provided, but where select diagnostic services, such as HIV testing, are offered. A key feature of nonclinical settings is their location *within* the community—whether at fixed venues, outreach sites, or in a person's home, nonclinical settings are easily accessible and comfortable for populations who might not access medical services regularly.

#### Program Guidance - PAHR:

To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish targets for key program indicators, and monitor service delivery to ensure targeted testing is achieving program goals. Sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Funded providers should present confidential HIV testing as the default option for all persons requesting an HIV test. Funded providers should establish partnerships with organizations that offer essential follow-up services.

#### **Linguistic Services**

Linguistic Services provide interpretation and translation services, both oral and written, to eligible customers. Qualified individuals must provide these services as a component of HIV service delivery between the healthcare provider and the customer. Agencies should provide these services when such services are necessary to facilitate communication between the provider and customer or support the delivery of eligible services.

#### Program Guidance - PAHR

This service is not funded through HCS. HSC service providers should link PAHR customers to community resources based on need.

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<sup>11</sup> PCN 11-01 [The Use of Ryan White HIV/AIDS Program Funds for Housing Referral and Short-term or Emergency Housing Needs](#)

### Program Guidance - PLWH:

Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

### **Medical Case Management Services**

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

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous customer 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 customer's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments and prevention regimens
- Customer-specific advocacy or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible customers in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, health care and supportive services, and insurance plans through the health Insurance Marketplaces/Exchanges).

### Program Guidance – PAHR and PLWH:

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management have as their objective providing guidance and assistance in improving access to needed services.

Visits to ensure readiness for, and adherence to, complex HIV treatment and prevention regimens are part of Medical Case Management. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

### **Medical Nutrition Therapy**

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation

- Food and/or nutritional supplements per medical provider’s recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services

Program Guidance - PAHR

This service is not funded through HCS. HSC service providers should link PAHR customers to community resources based on need.

Program Guidance - PLWH:

All services performed under this service category must be pursuant to a medical provider’s referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

Note: Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services.

**Medical Transportation**

Medical transportation is the provision of nonemergency transportation services that enables an eligible customer to access or be retained in core medical and support services.

Program Guidance - PAHR:

This service is not funded through HCS. HCS service providers should link PAHR customers to community resources based on need.

Program Guidance - PLWH:

Medical transportation may be provided through:

- Contracts with providers of transportation services
- Voucher or token systems
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)

Unallowable costs include:

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

**Mental Health Services**

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to customers living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by

a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance - PAHR:

This service is not funded through HCS. HCS service providers should link PAHR customers to community resources based on need.

Program Guidance PLWH:

Mental Health Services are allowable only for HIV-infected customers.

**Non-Medical Case Management**

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. NMCM services may also include assisting eligible customers to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including fact-to-face, phone contact, and any other forms of communication deemed appropriate by the recipient. Key activities include:

- Initial assessment of service needs
- Development of comprehensive, individualized care plan
- Continuous customer 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 customer's and other key family members' needs and personal support services

Program Guidance – PAHR and PLWH:

NMCM services have as their objective providing guidance and assistance in improving access to needed services whereas Medical Case Management have as their objective improving health care outcomes.

**Outreach Services**

Outreach Services for PLWH include the provision of the following activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services
- Recruitment to HIV Community Services.

Outreach Services for PAHR may include the provision of the activities above but must be bundled with one or more direct service including, but not limited to, HIV testing, condom distribution, healthcare navigation/coordination, and insurance enrollment/navigation. Outreach services will not be funded as stand-alone activities.

#### Program Guidance PAHR and PLWH:

Outreach programs must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection or exhibiting high-risk behavior
- Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Agencies providing services to PLWH may not use funds to pay for HIV counseling or testing under this service category. Agencies cannot deliver Outreach services anonymously as personally identifiable information as the Department needs data about customers for program reporting (see Policy Notice 12-01<sup>12</sup>)

#### **Population Based Services**

Population based services focus on the overall customer populations served, on population health needs, and on community empowerment to help populations better understand and use healthcare and ARVs for PrEP and treatment. These services will be the driver of new customers to the HCS system.

These services may include:

- Community-level strategies to identify and understand population needs.
- Community-level strategies to engage, mobilize, and empower communities to seek healthcare services including health insurance, HIV testing, PrEP, and HIV treatment.

#### Program Guidance – PAHR, PLWH:

Population based services must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection or exhibiting high-risk behavior
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

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<sup>12</sup> Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Service

Population Based Services for PLWH and PAHR must be bundled with a direct service including, but not limited to, HIV testing, condom distribution, healthcare navigation/coordination, and insurance enrollment/navigation. Population based services will not be funded as stand-alone activities.

### **Psychosocial Support Services**

Psychosocial Support Services provide group or individual support and counseling services to assist eligible PLWH and PAHR to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respice support
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietician
- Pastoral care/counseling

#### Program Guidance, PAHR:

- Fundable psychosocial support services for PAHR are limited. Funds under this service category may only be used to achieve outcomes associated with initiating and/or sustaining ARVs for PrEP.

#### Program Guidance - PLWH:

- Funds under this service category may not be used to provide nutritional supplements.
- Funded pastoral counseling must be available to all eligible customers regardless of their religious denominational affiliation.
- Agencies may not use funds for social/recreational activities or to pay for a customer's gym membership

### **Substance Abuse Services Outpatient Care**

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
  - Pretreatment/recovery readiness programs
  - Harm reduction
  - Behavioral health counseling associated with substance use disorder
  - Outpatient drug-free treatment and counseling
  - Medication assisted therapy
  - Neuro-psychiatric pharmaceuticals
  - Relapse prevention

Program Guidance - PAHR:

This service is not funded through HCS. HCS service providers should link PAHR customers to community resources based on need.

Program Guidance – PLWH:

Acupuncture therapy may be allowable under this category only when, as part of a substance use disorder treatment and included in a documented plan.

## Appendix 3: Service Levels

| HIV Community Services                            | Service Levels   |   |  |
|---|--|---|--|
|   | Population   | Minimum   | Medium to High   |
|   | Workforce Competencies   |   |  |
|   | Work to help <b>communities</b> identify and understand their needs and healthcare options and engage, mobilize, and empower communities to seek healthcare services including health insurance, HIV testing, PrEP, and HIV treatment.   | Work with <b>individual</b> customers with minimal needs. Must be skilled at basic care navigation and coordination and recognizing when a customer needs to be referred to higher level services.  | Works with <b>individual</b> customers with more complex needs. Greater expertise to help customers engage with more complicated healthcare services while at the same time addressing co-occurring conditions.  |
| Service Activities (Examples)                     |  |   |  |
| <b>Educate communities and individuals</b>        | <ul style="list-style-type: none"> <li>Expand community knowledge and awareness of health insurance, PrEP, HIV treatment and the prevention care and treatment system, etc</li> <li>Promotion of social marketing campaigns, social media and other educational materials</li> <li>Other community-level education strategies</li> </ul> | <ul style="list-style-type: none"> <li>Assessment of service needs</li> <li>Development of individualized care plan</li> <li>Individual customer education to influence health-related information, attitudes, and behaviors</li> <li>Other individual-level education strategies</li> </ul>                          | <ul style="list-style-type: none"> <li>Connect to other services based on customer need</li> </ul>   |
| <b>Recruit new customers to services</b>          | <ul style="list-style-type: none"> <li>Drive new customers to HCS</li> <li>Other community-level recruitment strategies</li> </ul>   | <ul style="list-style-type: none"> <li>Connect to other services based on customer need</li> </ul>  | <ul style="list-style-type: none"> <li>Connect to other services based on customer need</li> </ul>   |
| <b>Identify Undiagnosed HIV and STD Infection</b> | <ul style="list-style-type: none"> <li>Promote community-level strategies to mobilize customers to test frequently</li> <li>Other community-level strategies to identify undiagnosed HIV infection</li> </ul>  | <ul style="list-style-type: none"> <li>Assessment of service needs</li> <li>Development of individualized care plan</li> <li>Provide nonclinical HIV and STD test</li> <li>Active follow up and testing reminders</li> <li>Other individual-level strategies to identify undiagnosed HIV and STD infection</li> </ul> | <ul style="list-style-type: none"> <li>Monitor customer to assess efficacy of care plan</li> <li>Promote individual-level strategies to mobilize customers to test frequently</li> <li>Implement individual level evidence-based intervention that address co-factors that create barriers to frequent HIV and STD testing and/or meets customer's needs</li> <li>Connect to other services based on customer need</li> <li>Other individual-level strategies to promote frequent testing</li> </ul> |

| HIV Community Services                 | Service Levels   |  |  |
|--|--|--|--|
|  | Population   | Minimum  | Medium to High   |
|  | Workforce Competencies   |  |  |
|  | Work to help <b>communities</b> identify and understand their needs and healthcare options and engage, mobilize, and empower communities to seek healthcare services including health insurance, HIV testing, PrEP, and HIV treatment. | Work with <b>individual</b> customers with minimal needs. Must be skilled at basic care navigation and coordination and recognizing when a customer needs to be referred to higher level services.   | Works with <b>individual</b> customers with more complex needs. Greater expertise to help customers engage with more complicated healthcare services while at the same time addressing co-occurring conditions.  |
| Service Activities (Examples)          |  |  |  |
| <b>Enroll in health insurance</b>      | <ul style="list-style-type: none"> <li>Promote community-level strategies to enroll customers in health insurance</li> <li>Other community-level strategies to enroll customers in health insurance</li> </ul>                         | <ul style="list-style-type: none"> <li>Assessment of service needs</li> <li>Development of individualized care plan</li> <li>Assist in health insurance enrollment</li> <li>Build health insurance literacy</li> <li>Active follow up and appointment reminders</li> <li>Other individual-level strategies to enroll in health insurance</li> </ul>  | <ul style="list-style-type: none"> <li>Connect to other services based on customer need</li> </ul>   |
| <b>Initiate and sustain healthcare</b> | <ul style="list-style-type: none"> <li>Promote community-level strategies to assist customers in initiating healthcare services</li> <li>Other community-level strategies to promote initiation of healthcare</li> </ul>               | <ul style="list-style-type: none"> <li>Assessment of service needs</li> <li>Development of individualized care plan</li> <li>Linkages to identified resources</li> <li>Assist in the initiation, utilization, and maintenance of supportive healthcare services</li> <li>Expand access to physical and behavioral healthcare services</li> <li>Increase points of entry for access to healthcare services</li> <li>Active follow up and appointment reminders</li> <li>Other individual-level strategies to assist in initiating and sustaining healthcare services</li> </ul> | <ul style="list-style-type: none"> <li>Provide case management services (medical and non-medical)</li> <li>Monitor customer to assess efficacy of care plan</li> <li>Build on and create support systems to strengthen medical care and support services</li> <li>Provide individual level, evidence-based intervention that addresses co-factors that create barriers to initiating and/or sustaining healthcare and/or meets customer need</li> <li>Re-engage out of care customers</li> <li>Connect to other services based on customer need</li> </ul> |

| HIV Community Services    | Service Levels  |  |  |
|---------------------------|---|--|--|
|                           | Population  | Minimum  | Medium to High   |
|                           | Workforce Competencies  |  |  |
|                           | Work to help <b>communities</b> identify and understand their needs and healthcare options and engage, mobilize, and empower communities to seek healthcare services including health insurance, HIV testing, PrEP, and HIV treatment.  | Work with <b>individual</b> customers with minimal needs. Must be skilled at basic care navigation and coordination and recognizing when a customer needs to be referred to higher level services.   | Works with <b>individual</b> customers with more complex needs. Greater expertise to help customers engage with more complicated healthcare services while at the same time addressing co-occurring conditions.  |
|                           | Service Activities (Examples)   |  |  |
| Initiate and sustain ARVs | <ul style="list-style-type: none"> <li>Promote community-level strategies to assist PAHR in initiating PrEP</li> <li>Promote community-level strategies to assist PLWH in initiating HIV treatment</li> <li>Other community-level strategies to promote initiation of ARVs</li> </ul> | <ul style="list-style-type: none"> <li>Assessment of service needs</li> <li>Development of individualized care plan</li> <li>Linkages to identified resources</li> <li>Assist individuals in adhering to ARVs</li> <li>Active follow up and appointment reminders</li> </ul> | <ul style="list-style-type: none"> <li>Provide case management services (medical and non-medical)</li> <li>Monitor customer to assess efficacy of care plan</li> <li>Build on and create support systems to strengthen medical care and support services</li> <li>Provide evidence-based intervention to persons who are out-of-care that helps address barriers to care and/or meet customer needs</li> <li>Provide evidence-based medication adherence intervention that addresses ongoing barriers to ARV adherence and/or meets customer's needs</li> <li>Re-engage out of care customers</li> <li>Connect to other services based on customer need</li> </ul> |

## Appendix 4: Financial and Administrative Considerations

### **Financial and Administrative Considerations for Evaluation of HIV Community Service Request for Applications (RFA) Before Awarding Funding**

- If organization has contracted with DOH previously, review history, accuracy, and timeliness of submission of reports, fiscal reports, budget requests, and invoices.
- Request written policies and procedures for handling all financial transactions (back up documentation including receipts, invoices, disbursements, authorizations, etc.).
- Request payroll policies and procedures.
- Check to make sure the organization has not been suspended or debarred.
- Check to find out if any lawsuits have been filed against the organization.
- Request copies of insurance coverage.
- Request written work flow of accounting procedures to ensure an adequate system of checks and balances.
- Request Board minutes.
- Request copies of staff licenses and certifications and make sure they are current.
- Request customer eligibility policies and procedures.
- Request organization's travel policies and procedures.
- Request the organization's federally approved negotiated indirect cost rate plan or cost allocation plan if the organization has one.
- Review organization's financial stability and capacity.
  - Review past compliance issues and/or audit findings and the timeliness with which they were resolved.
  - Review DOH's risk assessment, "Capability & Oversight Assessment Tool" (COAT) and DOH contractor comments.
  - Request financial and audit reports (State Auditor, A-133 reports).
  - Ensure the organization has the capacity to do business on a cost reimbursement basis.
- Ensure the organization's accounting system has the capacity to separate funding sources.
- Request privacy policies and procedures for handling and storing confidential information.
- Request equal opportunity and discrimination policies.
- Request certification of a drug-free workplace.