

# Compendium of Services: CARE Act Part A and Part B

Government of the District of Columbia  
Department of Health  
HIV/AIDS Administration

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## Introduction

The Compendium of Services: CARE Act Part A and Part B is intended to establish a clear and firm foundation for the important work of providing services to individuals with HIV/AIDS, and to assist sub-grantees of CARE Act Part A or Part B funds to plan and provide the necessary services to enroll and retain clients in care, all with the goal of improving the health of those served.

In May, 2007, the federal Health Resources and Services Administration (HRSA) released a list of services that can be supported with CARE Act Part A or Part B funding. This compendium provides for each the key goals and priorities of the service as well as the service definition.

The HIV/AIDS Administration remains committed to active, ongoing partnership with each provider of HIV care and treatment services, and will assist any provider in their efforts to achieve the maximum benefit for clients in need.

A note on numbering: Categories included in this Compendium are those supported through the CARE Act Part A and Part B programs of the District of Columbia. Service categories that are permissible, but not included, leave gaps in the sequential numbering.

## Category 1: Outpatient and Ambulatory Medical Care

### Goals and Priorities

Every indication suggests that Outpatient and Ambulatory Medical Care remains challenged by sub-optimal outcomes, irregular use of services and low rates of viral suppression for clients in care, and by significant numbers of people with HIV dropping out of care. In addition, as the number of persons accessing care expands, it is critical to ensure enrollment in other payer systems such as Medicaid and the DC Alliance is maximized to bring the most resources available into the HIV response. It is also critical that prevention and harm reduction messages are routinely provided during primary care. The District of Columbia seeks supports Outpatient and Ambulatory Medical Care that include strategies and activities designed to address these issues.

Outpatient and Ambulatory Medical Care should specifically address:

- ◆ Strategies to maximize clinical health outcomes, including description of baseline outcomes and projected targets. Specifically:
  - ◆ How adherence (to appointments, as well as to HIV medications) is routinely and comprehensively addressed. HAHSTA expects that promotion of adherence will be a part of almost every interaction with clients. Describe how these strategies are routinely reviewed and assessed for success.
  - ◆ The number and type of clients currently in care, the proportion on antiretroviral therapy, the proportion on ART regimen for longer than six months with undetectable viral load and targets for these variables during the grant period.

- ◆ Plan for achieving and maximizing health outcomes, including viral suppression. Evidence suggests that durable viral suppression rates higher than ninety percent of clients can be achieved.
- ◆ Plan to ensure that all needed services of clients are addressed, either directly by the organization providing ambulatory outpatient medical care, or indirectly through a demonstrated partnership.
- ◆ Strategies to perform HIV ant-retroviral resistance profiles in accordance with USPHS Guidelines, including baseline and projected number of clients and tests performed. Costs for projected resistance testing should be included in laboratory budget items.
- ◆ Current and proposed strategies and tools routinely used to screen for mental health and substance abuse issues, the standardized assessment tools used, and which staff of the care team routinely administers these assessments. Describe follow-up and linkages for clients screening positive for substance abuse and mental health needs.
- ◆ Strategies to optimize retention in care. Optimal retention includes at least one contact with a licensed medical professional in the past 6 months, with 2 or more visits during the past 12 months. No-show rates for appointments should be minimized through active efforts. Applicants should clearly describe baseline values as well as program targets for these indicators. Assessing clients for needed services, including adequate co-management of mental health and substance abuse issues through direct provision or linked partners, is often critical to retention.
- ◆ Strategies to ‘recapture’ clients previously in care who have been lost to follow-up. Some providers in DC have recently achieved a 80% recapture rate (including identifying when clients lost to follow up are now accessing care elsewhere) through strategies such as: reviewing records of clients who have been out of care; designing and conducting “inreach” activities to re-establish contact with clients; incentivizing staff to achieve recapture goals. Experience suggests that inreach can be successful, but requires a sustained effort and frequently persistent, multiple (greater than ten) attempts to re-establish contact. Success often also includes identifying and resolving transportation, language or other barriers that have contributed to the client having been out of care.
- ◆ Strategies to maximize screening for, enrollment in, and billing of other payer systems such as Medicare, Medicaid and Alliance. Proportion of current clients in your organization with payers other than Ryan White should be described. A description of the finding of any reviews that have been done in the past 12 months to assess applicant’s success in screening clients and enrollment in other systems should be included here. System for regular review of optimal eligibility screening and outcomes during grant period should be described here. Applicants with a particularly low rate of clients who are eligible for other payers should describe the unique characteristics of their clientele that contribute to this finding (i.e., major reasons why the clients do not meet other eligibility criteria).
- ◆ Strategies to include core prevention and harm reduction messages in routine ambulatory outpatient medical care services. This should include: provision of condoms and other safer sex products; linkages to prevention-for-positive programs for those with need; linkages to services for persons with compulsive behaviors; provision of or linkages to

harm reduction programs such as needle exchange services; and consideration of emphasize on compliance with HIV medications and viral suppression as a risk reduction strategy.

Ambulatory Outpatient Medical Care supported by CARE Act Part A, Part A MAI and Part B funds are primarily – but not exclusively -- those that are supported by Medicaid in the District of Columbia. (For example, activities designed to return a client to care may not be permissible under Medicaid, but are permissible under CARE Act requirements.) Providers of Ambulatory Outpatient Medical Care are required to be certified by the District of Columbia Department of Health Care Finance, and are also required to bill and collect Medicaid and other third-party revenue for services provided.

## Definition

Primary and specialty medical care for the treatment of HIV infection is the provision of care consistent with the United States Public Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. Outpatient/Ambulatory medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes, 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).

## Category 2: AIDS Drug Assistance Program

AIDS Drug Assistance Program (ADAP Treatments) is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

## Category 3: AIDS Pharmaceutical Assistance

AIDS Pharmaceutical Assistance (local) 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.

**NOTE:** Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

## Category 4: Oral Health Care

Oral health care is the provision of preventive oral hygiene and infection control through integrated health management. Sub-grantees of oral health care will demonstrate how services will help to address the burden placed on the immune system caused by oral infection and

support positive health outcomes. Challenges in this service category have included lack of availability of expanded clinic hours, especially for clients who have returned to the workforce; unreasonably long wait time between referral and appointments and with inadequate appointment reminders resulting in high no-show rates.

Sub-grantees will address the following:

- ◆ Strategies for ensuring meaningful and easy access to services, including
  - ◆ Availability of expanded clinic hours for evenings or weekends
  - ◆ Management of appointments to reduce waiting time between referral and appointment date, and reminder strategies to reduce no-show burdens. Sub-grantees will state the target appointment wait time for urgent dental issue and for routine dental issues, and will monitor achievement of these targets as well as no-show rates.
  - ◆ Services that promote routine oral health awareness and maintenance.

## Definition

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and other trained primary care providers. Dentures essential for the maintenance of health will be included.

Key activities include:

- ◆ Initial examinations
- ◆ Cleanings
- ◆ Fillings
- ◆ Extractions
- ◆ Root canals
- ◆ Linkages to referral sources to provide portions of services not provided by applicant

## Category 5: Early Intervention Services

### Goals and Priorities

Early Intervention Services will emphasize ensuring the movement of clients along the prevention to care continuum – specifically ensuring linkage to and retention in care and improved health outcomes. These services will be provided to individuals with a diagnosis of HIV infection, who are consistent with current understanding of populations at elevated risk for poor engagement in care or loss to care. Eligible clients will include individuals with a preliminary – but not necessarily confirmed – diagnosis of HIV infection.

HAHSTA considers populations at elevated risk for poor engagement in care or loss to care to include:

- ◆ Transgendered individuals

- ◆ Commercial sex workers
- ◆ Deaf or hard of hearing individuals
- ◆ Individuals 50 years and older
- ◆ Immigrants in the country less than 12 months
- ◆ Individuals with physical, mental or developmental disabilities
- ◆ Individuals between the ages of 15 and 25, and especially those in transition from pediatric to adult care
- ◆ Marginally housed or homeless
- ◆ Incarcerated and recently released individuals
- ◆ Substance abusers
- ◆ Individuals with low literacy or health literacy
- ◆ Individuals with a DSM IV mental health diagnosis.

Applicants may choose to target a population other than those listed above, and demonstrate in the application the evidence for characterizing the targeted population as being at elevated risk for poor engagement in care or loss to care.

Local surveillance data indicate relatively high rates of people with HIV remaining unaware of their infection until the relatively late stages of the disease. Early Intervention Services are intended to assist these populations at earlier stages of the disease, and ensure effective linkage with health care services at the earliest stages possible. This includes engaging persons who have been previously diagnosed with HIV but have never successfully been engaged in care.

HAHSTA seeks providers of Early Intervention Services (EIS) that are highly intensive and take into account time of day, events, sites, method, and cultural appropriateness.

### **Definition**

Early Intervention Services include counseling individuals with respect to HIV/AIDS; testing including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests 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 providing therapeutic measures.

Successful applicants must demonstrate their ability to identify clients for Early Intervention Services, but may not include the costs of the outreach as part of the funding proposed or budgeted for Early Intervention Services.

HAHSTA will promote Early Intervention services for individuals within and outside traditional medical settings by working with providers to reach those who have been diagnosed with HIV but who are not receiving treatment and care.

Applicants proposing to provide early intervention services must describe their proposed program components and detail how it will support the service category program activities. Proposal should include.

- ◆ A detailed and clear plan to move clients along the prevention to care continuum, from diagnosis, linkage to care and other services, offering of antiretroviral treatment, adherence to medication and medical care, retention in medical care, re-engagement in care and improved health outcomes.
- ◆ A detailed and clear plan to ensure that clients from among the target populations are effectively linked with HIV primary medical care, medical case management, mental health and substance abuse services as appropriate
- ◆ A detailed and clear plan to provide intensive and focused services to these populations within the first 3 months of linking them to care to support retention and adherence to care.
- ◆ Services to people with HIV who are aware of their HIV infection but not enrolled in primary medical care.
- ◆ Exclude general awareness or education efforts or broad based testing
- ◆ Formal agreements with organizations if the plan for delivering any required early intervention services relies on working cooperative with one or more other organization, including identified point(s) of entry. Such agreement will outline respective responsibilities for engaging the client in care and methods of ongoing coordination.

## Category 6: Health Insurance Premium & Cost Sharing Assistance

Health Insurance Premium & Cost Sharing Assistance is 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.

## Category 8: Home and Community Based Health Services

### Goals and Priorities

Home and Community Based Care support the provision of day treatment programs. Providers of this service can propose to provide medical and/or non-medical services. Non-Medical day treatment should include the provision of non-medical ancillary services during morning and afternoon hours by community based organizations (non-hospital) for persons living with HIV/AIDS who do not qualify for other Medicaid funded programs. If proposing medical day treatment services, appropriate Medicaid certification is necessary.

Providers of Home and Community Based Care will promote the availability of their service, including

- ◆ Communication strategies to make other service providers aware of this service for referral of their clients.
- ◆ Description of hours of operation and why they are most appropriate for target population.
- ◆ Proposed strategies to ensure strong linkages to other care and support services.
- ◆ Baseline and projected target numbers of clients served with which services, including duration of participation in these services, what criteria suggest that transition out of the program is needed, and how transition out of these services is effectively supported.

## Definition

Home and community-based health services include skilled health services furnished to an 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.

Key activities include

- ◆ The provision of durable medical equipment
- ◆ The provision of home health aide services and personal care services in the home
- ◆ Provide 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
- ◆ Appropriate mental health, developmental, and rehabilitation services.

Inpatient hospitals services, nursing home and other long term care facilities are NOT included.

## Category 10: Mental Health Services

### Goals and Priorities

Mental illness not only causes direct harm and suffering and may be a considerable barrier to developing and maintaining social support networks, but also contributes significantly to the inability of people with HIV to consume critically needed services to improve and maintain overall health. The District of Columbia, Department of Health supports services to improve the mental health status of clients, improve the stability of clients served and enable clients to become and remain fully engaged in their own health care.

Mental Health Services supported by CARE Act Part A, Part A MAI and Part B funds are those that are supported by Medicaid in the District of Columbia. Providers of Mental Health are required to be certified by the District of Columbia Department of Mental Health (or its successor organization), and are also required to bill and collect Medicaid and other third-party

revenue for services provided. Please see “Psychosocial Support Services” for other services that do not require Medicaid certification.

Mental Health Services include:

- ◆ Strategies to ensure joint medical management with HIV primary care, substance abuse, and case management providers, including any routine communications or case conferences. This includes specific attention to understanding the medical management needs of clients with regards to ART adherence and viral suppression when applicable, as well as ensuring that primary medical providers are aware of mental health treatment plan. Barriers to such joint medical management should be clearly described and solutions proposed. Linkages with specific providers should be clearly detailed.
- ◆ Current and proposed strategy to support retention in mental health and care services. This should include current tracking, reminder, and support system to minimize no-show rate and most of all minimize loss to follow-up. Retention and no-show rates for scheduled appointments should be provided as baseline and targets.
- ◆ Proposed strategy to recapture clients previously lost to follow up. Goals may be to re-engage clients into mental health services or to confirm that these services are not currently needed. Applicants should describe current lost-to-follow-up rate, and describe common reasons for loss.
- ◆ Demonstration of certification from the DC Department of Mental Health to provide and seek reimbursement for services. Proposals from agencies that are not certified by the Department of Mental Health should indicate their plan and time line to secure certification. Describe Medicaid certification for mental health services.
- ◆ Current and proposed strategies to include core HIV prevention and harm reduction messages in routine care services. This should include any plans to routinely provide: risk screening and counseling; condoms and other safer sex products; linkages to prevention-for-positive programs; services geared towards compulsive behaviors; provision of or linkages to harm reduction programs such as needle exchange services if appropriate; and consideration of emphasize on ART compliance and viral suppression as a risk reduction strategy.

## Definition

Mental health services are psychological and psychiatric treatment and counseling services to individuals with HIV and a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such service, which includes psychiatrists, psychologists and licensed clinical social workers. Services must be based on specific treatment goals and be led by professional therapists.

Key activities include:

- ◆ Initial evaluation
- ◆ Individual, couple, and group psychotherapy
- ◆ Psychiatric, psychological, and/or neuro-psychological assessments

- ◆ Treatment planning and monitoring
- ◆ Psychopharmacology medications

Activities may also include

- ◆ Professionally facilitated support groups as well as spiritual and bereavement counseling
- ◆ Participation on a multidisciplinary team

## Category 11: Medical Nutrition Therapy

Nutritional status is a strong predictor of survival and functional status for persons with HIV disease. Medical Nutrition Therapy can be a critical part of the continuum of primary medical care, and is consistently ranked high by the designated planning body for Ryan White Services.

Medical Nutrition Therapy should specifically include:

- ◆ A description of the population to be served Medical Nutrition Therapy with respect to their need for Medical Nutrition Therapy. Baseline and targets of number of clients to be served, and with what frequency and duration should be specifically included.
- ◆ The likely impact of the addition of Medical Nutrition Therapy to the health status of the clients served.
- ◆ Proposed strategy to ensure direct linkages with primary medical provider to ensure specific needs related to medical issues and drug treatments are known and nutritional plans are understood by medical provider.

### Definition

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy has the goal of developing healthy dietary regimens for people who are HIV positive and gives special consideration to the client's drug regimen. Information on safe drinking water should be provided. The provision of medical nutrition therapy in a primary care setting is the preferred approach for care.

Key activities include:

- ◆ Risk screening
- ◆ A complete baseline nutritional assessment
- ◆ Development of a tailored nutritional plan
- ◆ Nutritional consultations with other primary healthcare and supportive service providers
- ◆ Ongoing assessments and treatment including self-care training, nutrition education and counseling
- ◆ Participation on a multidisciplinary team

## Category 12: Medical Case Management

### Goals and Priorities

The primary goal of this service is to assess the need of clients for services, coordinate the provision of services, provide the necessary support and managements to maintain clients in care, all with the ultimate goal of improving health outcomes. Medical case management seeks to maximize the ability of each client to manage his or her own care, while at the same time ensuring that the service needs of clients are understood and addressed.

Medical Case Management services may provide onsite with other core medical services or may be provided off-site or associated with other support services. Whether provided on-site or off-site with primary medical care, the Medical Case Management activity must be clearly and demonstrably integrated into the provision and evaluation of ambulatory outpatient medical care, and demonstrate routine dialogue with the primary medical care team.

Medical Case Management can be a critical service for ensuring comprehensive care and good medical and quality of life outcomes for persons with complicated medical and social support needs. It links clients to appropriate entitlement and support services and serves as a portal for critical client education. For clients who are experiencing extreme difficulty in maintaining participation in care services, case management may be the final connection to ensure that clients are not completely lost to follow up while these difficulties are overcome.

Medical Case Management should specifically include the following:

- ◆ Current and proposed strategy for ensuring direct linkage and routine dialogue with primary medical care team. This description should specifically include what types of data are exchanged and how, critical 'red flags' that drive urgent dialogue and exchange. System of this level of co-management should also be described for mental health and substance abuse services for clients with multiple diagnoses. Linkages to other medical and support services should also be described.
- ◆ Proposed strategy to optimize adherence and ART treatment outcomes. Specific attention to regular attendance of scheduled medical appointments and specific discussion of viral load results are critical for supporting successful treatment outcomes and not just successful processes. Case management providers will document viral load results of client in coordination with the primary care provider, and incorporate the results into feedback, counseling, and adherence support response. Mechanisms for providing feedback to medical providers on specific adherence issues identified (such as side effects) and mechanisms to build skills with clients to interact with medical providers on their own issues should also be provided
- ◆ Medical case managers will, in coordination with providers of ambulatory outpatient medical care, monitor and report the total number of current clients, the number and proportion of current clients are on HIV anti-retroviral, and the number and proportion with an undetectable viral load. Targets for achieving health outcomes are identical to those of providers of ambulatory outpatient medical care.

- ◆ Current and proposed strategies for providing appropriate levels of case management. Clients require different levels of support over time. Not all clients require the same intensity and complexity of interactions, and most clients vary over time in the intensity and complexity of supports required. Case management providers will describe how level of care is assessed and categorized, and how clients are moved from one level to another over time, and report on the number and proportion of clients by level of need. Describe techniques to maintain clients in care and to recapture those who have fallen out of care or been lost to follow-up.
- ◆ Strategies to optimize retention in care. Optimal retention includes at least one contact in the past 6 months, with 2 or more visits during the past 12 months. No-show rates for appointments should be minimized through active efforts. Applicants should clearly describe baseline values as well as program targets for these indicators. Assessing clients for needed services, including adequate co-management of mental health and substance abuse issues through direct provision or linked partners, is often critical to retention.
- ◆ Strategies to ‘recapture’ clients previously in care who have been lost to follow-up. Some providers in DC have recently achieved a 80% recapture rate (including identifying when clients lost to follow up are now accessing care elsewhere) through strategies such as: reviewing records of clients who have been out of care; designing and conducting “inreach” activities to re-establish contact with clients; incentivizing staff to achieve recapture goals. Experience suggests that inreach can be successful, but requires a sustained effort and frequently persistent, multiple (greater than ten) attempts to re-establish contact. Success often also includes identifying and resolving transportation, language or other barriers that have contributed to the client having been out of care.
- ◆ Current and proposed strategies to include core HIV prevention and harm reduction messages in routine care services. This should include: provision of condoms and other safer sex products; linkages to prevention-for-positive programs for those with need; linkages to services for persons with compulsive behaviors; provision of or linkages to harm reduction programs such as needle exchange services; and consideration of emphasize on ART compliance and viral suppression as a risk reduction strategy. Any specific strategies to support appropriate disclosure and development of social support networks by clients should be described.
- ◆ Proposed strategy for supervision, quality management, and customer service. This should include approach to mediating disputes between case managers and clients. Describe what systems are implemented and with what frequency to evaluate quality and performance of case managers. Describe trainings or interventions provided to support quality improvement routinely and when deficiencies are identified. Quantify stability of case managers (what % of your case managers have been with your organization 2 years or more) as well as retention strategies for case managers. Describe performance expectations for timeliness of return of client calls, timeliness and completeness of follow up on paperwork submission, etc.

## Definition

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The

coordination and follow-up of medical treatments is 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's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Key activities include:

1. Initial assessment of service needs
2. Development of a comprehensive, individualized service plan including active client participation
3. A multi-disciplinary team approach to coordination of services required to implement the plan
4. Client monitoring to assess the efficacy of the plan
5. Periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management contact including face-to-face, phone, and any other forms of communication

## Case Management and Families

All clients served by CARE Act Part A, Part A MAI and Part B funds are individuals who are infected with HIV. In some cases, a limited set of services is available for family members who are not infected. In each case, there must be a clear, distinct and direct connection between the service provided to the non-infected individual and the health status of client with HIV.

For example, enrollment of families into benefits programs is permissible. A Mental Health or Psychosocial Support intervention could be provided to stabilize a family at risk for adverse consequences from detection or disclosure of HIV.

## Case Management and the Peri-Incarcerated

Generally, CARE Act funded services are not provided to individuals while in custody. Provision of medical case management to individuals preparing for release from custody is permissible. Providers should establish relationships with entities that include, but are not limited to, parole points, halfway houses, and placement centers within the District of Columbia as forms of outreach.

## Category 14: Substance Abuse Services – Outpatient

### Goals and Priorities

Substance contributes significantly to the inability of people with HIV to consume critically needed services to improve and maintain health, and interferes with the ability of clients to develop and maintain critical social support networks. The District of Columbia, Department of

Health supports Substance Abuse Counseling to improve the health status of clients, improve the stability of clients served and enable clients to become and remain fully engaged in their own health care.

Substance Abuse Counseling Services should include:

- ◆ Current and projected ability to access and retain clients in care. Define baseline number and targets for clients served, measures of success, retention in services, and frequency and duration of services. Describe strategies to ‘recapture’ past clients who have been lost to follow up.
- ◆ Strategies to support ART readiness for those not on treatment and ART adherence and treatment outcomes for those currently on treatment. Clients with current or recent substance use often face unique challenges with medical providers in ART initiation, and often suffer from low treatment expectations of providers and occasionally themselves.
- ◆ Strategies for skills-building with clients to demonstrate stability and reliability to providers to overcome misperceptions—this may include regular attendance with medical appointments/focus on eliminating no-shows.
- ◆ Strategies for routinely reviewing documented viral load outcomes with clients on ART to provide specific feedback and support for successful outcomes.
- ◆ Describe your current and proposed use of the Addiction Prevention and Recovery Administration (APRA)-approved substance abuse assessment tools: GAIN (Global Appraisal, targeted for youth assessment, official certification available) and ASI (Addiction Severity Index). Agencies that are not currently using the APRA-recommended tools should include a plan and timeline for adopting them or explain thoroughly why they are not applicable to the proposed services. Any additional standardized tools routinely used for assessment and monitoring should be described.
- ◆ Strategies to ensure joint medical management with HIV primary care, mental health, and case management providers. This includes specific attention to understanding the support needs of clients with regards to ART adherence and viral suppression when applicable, as well as ensuring that primary medical providers are aware of substance use issues and progress when applicable. Barriers to such joint medical management should be clearly described and solutions proposed. Linkages with specific providers should be clearly detailed.
- ◆ Strategies to optimize retention in care. Optimal retention includes at least one contact in the past 6 months, with 2 or more visits during the past 12 months. No-show rates for appointments should be minimized through active efforts. Applicants should clearly describe baseline values as well as program targets for these indicators. Assessing clients for needed services, including adequate co-management of mental health and substance abuse issues through direct provision or linked partners, is often critical to retention.
- ◆ Strategies to ‘recapture’ clients previously in care who have been lost to follow-up. Some providers in DC have recently achieved a 80% recapture rate (including identifying when clients lost to follow up are now accessing care elsewhere) through strategies such as: reviewing records of clients who have been out of care; designing and conducting “inreach” activities to re-establish contact with clients; incentivizing staff to achieve

recapture goals. Experience suggests that inreach can be successful, but requires a sustained effort and frequently persistent, multiple (greater than ten) attempts to re-establish contact. Success often also includes identifying and resolving transportation, language or other barriers that have contributed to the client having been out of care.

- ◆ Current and proposed strategies to include core prevention and harm reduction messages in routine care services. This should include: risk analysis and perception; provision of condoms and other safer sex products; linkages to prevention-for-positive programs for those with need; linkages to services and peer support interventions for persons with compulsive behaviors; provision of or linkages to harm reduction programs such as needle exchange services if applicable; and consideration of emphasize on ART compliance and viral suppression as a risk reduction strategy.

Substance Abuse Services supported by CARE Act Part A, Part A MAI and Part B funds are those that are supported by Medicaid in the District of Columbia. Providers of Substance Abuse services are required to be certified by the District of Columbia Addiction Prevention and Recovery Administration (or its successor organization), and are also required to bill and collect Medicaid and other third-party revenue for services provided. Please see “Psychosocial Support Services” for other services that do not require Medicaid certification.

## Definition

Substance abuse outpatient treatment and counseling services are the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol, and or legal and illegal drugs, injection drugs and non-injection drugs) provided in an outpatient setting rendered by a physician or under the direct supervisor of a physician, or by other identified qualified personnel.

Further, as described in Allowable Uses of Funds for Discretely Defined Categories of Services, HRSA DSS Program Policy Guidance No. 2 (formally Policy No. 97-02), funds awarded under Part A or Part B of the CARE Act may be used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available.

Such services should be limited to:

- ◆ A pretreatment program of recovery readiness
- ◆ Harm reduction
- ◆ Mental health counseling to reduce depression, anxiety, and other disorders associated with substance abuse
- ◆ Outpatient drug-free treatment and counseling
- ◆ Methadone treatment
- ◆ Neuro-psychiatric pharmaceuticals
- ◆ Relapse prevention.

NOTE: CARE Act funds may not be used to fund syringe exchange.

CARE Act funds may be used for residential substance abuse treatment programs, including expanded HIV-specific capacity of programs if timely access to treatment is not available. The following limitations apply to use of CARE Act funds for residential services: because of CARE Act limitations on inpatient hospital care, CARE Act funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification is offered in a separate licensed residential setting (including a separately licensed detoxification facility within the walls of the hospital) or if the residential treatment service is in a facility that primarily provides inpatient medical or psychiatric care, the component providing the drug and/or alcohol treatment must be separately licensed for that purpose.

Key activities include:

- ◆ Client assessments
- ◆ Individual, couple, and group counseling
- ◆ Substance abuse index assessment
- ◆ Psychosocial assessment;
- ◆ Development of a treatment plan that outlines long-range goals and interventions for the client
- ◆ Participation on a multidisciplinary team

## Category 16: Child Care

### Goals and Priorities

The lack of Child Care can constitute a barrier to care for parents and other caregivers with dependent children. Child Care must be provided as a complement to other HIV-related services. For example, child care can be provided on-site at a medical clinic, or through voucher or other reimbursement method.

Please see category description below. Note that child care services are specifically to facilitate client's participation in core medical and support services, and CAN NOT be provided for respite care.

Child Care Services include:

- ◆ A description of the population to be served by Child Care Services, including baseline and targets of number of clients to be served, and with what frequency and duration.
- ◆ Thorough description of method of support—for example, on-site service, voucher, reimbursement, other. Plan should specifically describe checks and oversights to ensure that only eligible activities are charged to this service category.
- ◆ A discussion of the services complemented by the Child Care Services, and the likely impact of the addition of Child Care Services to the health status of the clients served.

## Definition

Child care services are 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.

## Category 18: Emergency Financial Assistance

### Goals and Priorities

This service category is intended to provide short-term, emergency relief for clients in periods of severe need, and will be designed to balance short-term relief with supporting the client to ensure longer-term resolution.

Emergency Financial Assistance will include:

- ◆ Use the full range of emergency financial assistance programs available to residents of the District of Columbia. This will ensure a full complement of support clients in need, as well as ensure that CARE Act funds are funds of last resort.
- ◆ Documentation of linkages with service providers who will refer clients for Emergency Financial Assistance and, in turn, ensure the longer-term needs of the client are addressed. Include communication strategies to inform service providers that Emergency Financial Assistance services are available.

## Definition

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, food (including groceries or food vouchers), and medication when other resources are not available.

NOTE: Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formerly Policy No. 97-02).

NOTE: Applicants proposing to provide housing assistance must provide services consistent with the HRSA housing policy found at <http://hab.hrsa.gov/tools/guidance/housing.htm>.

Key activities include:

- ◆ Emergency rental assistance (first month's rent or security deposits)
- ◆ Emergency utilities (gas, electric, oil and water) / telephone services
- ◆ Emergency food vouchers. Priority will be given to applicants proposing to provide more than one or all key activities listed.

- ◆ Improved coordination of services (see definition above #16)

## Category 19: Food Bank & Home Delivered Meals

### Goals and Priorities

Food Bank and Home Delivered Meals include:

- ◆ Coordination with ambulatory outpatient medical care and medical case management.
- ◆ A discussion of the impact and cost of the existing and proposed services. Include the total number of clients to be served (baseline and targets), average frequency and duration of services to individual clients, historical and projected cost per client per month.
- ◆ A description of the linkages to be established between the provider of Food Bank / Home Delivered Meals, and Outpatient Ambulatory Medical Care. In particular, describe the strategy to assess the impact of services provided in this service category on the health status of clients served.
- ◆ A discussion of alternate sources of food assistance, and a plan to ensure that clients are served by alternate sources to the fullest extent possible.
- ◆ Describe the demand for food assistance over the course of a given year, and the plan for ensuring the provision of adequate food support throughout the year.

### Definition

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 may be included. Vouchers to purchase food may be included. Cash disbursements or allotments are not permissible. Pet products, alcohol, tobacco products or other restricted items are not permissible.

Home Delivered Food key activities include:

- ◆ Providing home delivered meals, which shall include the delivery of prepared foods to homebound individuals and their dependents who are unable to prepare meals for themselves;
- ◆ The collection and delivery of perishable and nonperishable food items, personal care and/or household items and condiments for persons living with HIV/AIDS and their dependents that are homebound or shelter bound or unable to prepare meals for themselves or access other food programs like food banks;
- ◆ Development of meal plans by registered dietitians in coordination with the clients' caregivers, case managers and physicians;
- ◆ Providing information on safe drinking water on a regular basis as part of ongoing services; and
- ◆ Referrals to other food programs.

Food Bank key activities include:

- ◆ Providing food items, including fresh produce, poultry and fish;
- ◆ Improved coordination of services;
- ◆ Provision of services that include a mechanism for the delivery of food and/or filtered water to the homebound;
- ◆ Providing a minimal amount of safe drinking water in the event of a water emergency as declared by the jurisdiction's department of health; and
- ◆ Providing information on safe drinking water on a regular basis as a part of ongoing services.

## Category 22: Legal Services

### Goals and Priorities

Persons living with HIV/AIDS often encounter legal challenges that constitute a barrier to entering or remaining in care. Legal Services will be provided to support and stabilize the ability of clients to consume services, and to participate fully in their own care.

Legal Services will include:

- ◆ Baseline and target of clients to be served, with a description of how clients are assessed or referred to services;
- ◆ An estimate (targets) of the legal needs of clients by topic. Include any provision of dispute mediation services;
- ◆ Improved coordination of services; (see definition above #16)
- ◆ Demonstrated or planned ability to provide 'preventive' legal services, such as expertise in assessing eligibility criteria for publicly-funded benefits and entitlements, including housing and Medicaid. This 'preventive' approach helps to ensure that clients are accessing critical services to which they are entitled or eligible for, and is not just responding to clients who may have services discontinued; and
- ◆ A communications or linkages plan to promote the availability of this service to other service providers in the District of Columbia.

### Definition

Legal services are the provision of services to individuals with respect to powers of attorney, 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. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

The applicant is responsible for providing legal services in the following areas:

- ◆ Child custody
- ◆ HIV/AIDS discrimination
- ◆ Immigration, development of wills and trusts, durable powers of attorney and advanced directives
- ◆ Appeal of entitlement denials, breach of confidentiality, Do Not Resuscitate order, bankruptcy proceedings, guardianship, and other appropriate professional legal services
- ◆ Legal funds are not to be used for Class Action suits

NOTE: Attorneys providing services must be members of the State Bar Association or have the privilege of reciprocity.

## Category 23: Linguistic Services

### Goals and Priorities

Limited proficiency in the English language may impair the ability of clients to seek and consume services. .

Linguistic Services will include:

- ◆ A demonstrated capacity to routinely provide or rapidly mobilize translation services for Spanish-speaking clients.
- ◆ A demonstrated capacity to routinely provide or rapidly mobilize American Sign Language interpretation.
- ◆ The ability to provide upon request and within two working days translation services for clients who speak Amharic, Chinese, French, Korean or Vietnamese. The plan for services may include additional language capability.
- ◆ Description (baseline and targets) for number of clients to be served and in what capacity. Please describe fully what the proposed access points and eligibility are for the proposed services.
- ◆ A plan to promote the availability of these services to HIV service providers in the District of Columbia

### Definition

Linguistics services include the provision of interpretation and translation services.

Key activities include:

- ◆ The provision of interpreter services to assist limited English speaking individuals who need interpretation in order to be provided care, instructions, education and assistance in communication;
- ◆ Improved coordination of services; (see definition above #16)

- ◆ Sharing data on improved client access to services;
- ◆ Collaborating with medical providers to help improve access to care for all clients needing interpreter services; and
- ◆ Providing translators and interpreters with knowledge of HIV/AIDS terminology and the technical language and knowledge of health care terms.

Services include:

- ◆ American Sign Language and other language interpreters
- ◆ Voice relay
- ◆ Tactile or oral assistance.

## Category 24: Medical Transportation Services

### Goals and Priorities

The lack of Transportation can constitute a barrier to care. Medical Transportation Services offered and supported as a complement to other HIV-related services.

Proposals for Medical Transportation Services should specifically include

- ◆ Method and approach for supporting transportation, such as direct provision, vouchers, or reimbursement. Proposal may include requests to support clinic transport services.
- ◆ Please describe the role of the Medical Transport Services in re-engaging and recapturing clients who have been previously lost to follow up for care services

### Definition

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services

Key activities include:

- ◆ Providing transportation services to medical/clinical appointments for non-Medicaid eligible clients with HIV/AIDS
- ◆ Utilizing leased vans with drivers, a taxi voucher system, fare cards for metro rail, metro bus passes, disability commuter tickets, reimbursement's to family/friends for mileage and parking or a combination of approaches
- ◆ Providing appropriate modes of transportation for HIV disabled persons needing assistance or wheelchair accommodations
- ◆ Improve transportation services for clients with dependent children

## Category 26: Outreach Services

Outreach Services are programs that have as their principal purpose identification of people who know their status so that they may become aware of, and may be enrolled in care and treatment services. 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.

## Category 27: Psychosocial Support Services

### Goals and Priorities

Peer Counseling is supported under the service category Psychosocial Support Services. Currently, the District of Columbia Department of Health is encouraging and prioritizing topics detailed below.

- ◆ **Peer Navigation.** Newly-diagnosed people with HIV are frequently challenged by the unfamiliarity and complexity of the services available and may be overwhelmed by trying to learn the system of services. A peer support model can improve the ability of clients to understand the service systems and to consume service more effectively. This is a ‘learning the ropes’ model of peer support, and should include focus on skills-building for self-advocacy for a lifetime of care.
- ◆ **Social Support Network.** Evidence suggests that individuals without a sustaining social support network are more likely to fall out of care and engage in unhealthful behavior. Peer supports can help build clients build skills in creating and maintain a social support network, and may provide in itself a social support network around issues of disclosure of status, seeking services, maintaining adherence to drug therapies, and sustaining prevention measures. Direct peer support for prevention may be included in this category.
- ◆ **Compulsive Behavior and Harm Reduction.** People with both HIV and compulsive behaviors frequently benefit from participation in Twelve-Step and other self-help programs for compulsive behavior. A particular challenge is faced by individuals with HIV who are sexually compulsive, given the highly sensitive nature of discussion of HIV, HIV risk and sexually compulsion. A peer support group could provide valuable assistance to people with HIV who are sexually compulsive. In addition to providing peer support for reduced high-risk behaviors and including the increased use of condoms, programs should specifically include harm reduction approaches that focus on the non-sexual behaviors of regular participation in medical care, adherence to ART and focus on maintaining undetectable viral loads.

Psychosocial Support Services – Peer Counseling should include:

- ◆ A description of the population to be served by Psychosocial Support Services – Peer Counseling. Include target numbers, frequency, and duration of activities.
- ◆ The plan to ensure that peer counselors are appropriately trained and prepared to provide Peer Counseling and are provided with regular clinical supervision.
- ◆ Specific and detailed program approach aligned with one of the above priority topics, or justification, appropriateness, and impact of a different topic.

## Definition

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietician, but excludes the provision of nutritional supplements.

Key activities include:

- ◆ Completion of a comprehensive psychosocial assessment and linking client with counseling services as needed
- ◆ Support group services led or co-led by peer-facilitators
- ◆ Emotional support and didactic information related to medical or psychosocial issues; and bereavement counseling inclusive of spiritual support to persons with HIV/AIDS, their significant others and their caregivers

## Category 32: Treatment Adherence Counseling

### Goals and Priorities

The Department of Health seeks to improve the number of clients prepared to initiate and remain on HIV anti-retroviral therapy to achieve durable viral suppression. HAHSTA expects that virtually all interactions with clients will include consideration of retention in care generally, and adherence to treatment regimens specifically.

However, experience suggests that highly-vulnerable populations may be insufficiently supported in treatment adherence. This service category is intended to complement all other treatment adherence activities with a set of intensive, specialized services to those with intensive treatment adherence service needs.

Potential populations for intensive treatment adherence programs include individuals who have known barriers medication to adherence, have been failed by previous treatment regimens or who are otherwise at increased risk for treatment failure or non-adherence. Experience suggests that at least some individuals new to HIV anti-retroviral therapy may require specific support.

Treatment adherence service providers are responsible for planning, developing and implementing a medication adherence program, and will include:

- ◆ The eligibility criteria for recruitment and participation, including pathways for referral into the program. Describe how the program will complement or enhance the basic adherence supports that are a part of primary care and medical case management. Demonstrate why the proposed population is at uniquely high risk for non-adherence and poor medical outcomes or provide other justification for serving the target group.
- ◆ Plan how the proposed intervention is anticipated to improve adherence. Inclusive of any criteria utilized to determine when clients can step-down from intensive adherence monitoring to regular standard of care.
- ◆ Treatment adherence service providers must describe projected targets, including number, frequency, and duration of clients to be served as well as projected viral load suppression rates.
- ◆ Treatment adherence service providers should provide a baseline assessment of total number of current clients, their adherence to medical appointments, their prescribed use of HIV anti-retrovirals, their actual use of HIV anti-retrovirals, and the most recent viral load.
- ◆ Treatment adherence services providers, in coordination with ambulatory outpatient medical and medical case management providers, must document viral load results and apply client results to the service plan for the client.
- ◆ Treatment adherence service providers must include mechanism by which challenges (such as drug side effects) identified during adherence support may be fed back to the primary medical provider. Strategies should include skills-building with clients to provide feedback to their medical providers.
- ◆ Treatment adherence services providers must have a process for informing other providers or clients of the availability, accessibility and benefits of the AIDS Drug Assistance Program.

## Definition

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by medical or non-medical personnel outside of the medical case management and clinical settings. Peer experts may be successfully utilized in these models.