Non-Medical Case Management (NMCM) Minority AIDS Initiative (MAI) – Black Engagement and Retention in Care

Service Category Packet

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GENERAL APPLICATION INSTRUCTIONS

Step 1 – Review the entire Request for Application (RFA)

Read and review the entire RFA and this Service Category Packet for additional information related to agency and client eligibility, contract, insurance and audit requirements, and federal program requirements.

Step 2 - Agency Information Packet

Download, complete and submit **ONE** Agency Information Packet. Regardless of how many Service Category Packets your agency applies for, you only need to complete **ONE** Agency Information Packet.

- **Section A through D – Agency Information Packet**
    - *Where to find – Download the Agency Information Packet and write a narrative response to Sections A through D.*
- **Additionally, agencies must submit the following documents:**
    - A copy of your agency's most recent financial statement or audit. (If agency is not required to complete an audit or financial statement, provide a copy of your most recent 990 Form.)
    - New applicants should include a copy of the agency's certificate of nonprofit status

Step 3 – Service Category Packet

For each program area in which your agency would like to apply, download the Service Category Packet and complete and submit the following Sections.

- **Section A through D – Program Narrative Response**
    - *Where to find – The narrative questions are contained in this packet on page 3. Write a narrative response to Sections A and B, which describe the program.*
- **Form 1**, **Service Units Table**
    - *Where to find – Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The first tab is Form 1. Further instructions to complete the form are contained in this document.*
- **Form 2A**, **Personnel Budget**
    - *Where to find – Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The second tab is Form 2A. Further instruction to complete the form are contained in this document.*
- **Form 2B**, **Program Expenses**
    - *Where to find – Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The third tab is Form 2B. Further instructions to complete the form are contained in this document*.
- **Budget Narrative**
    - *Where to find – This is a free-form word document, and a template has not been provided. Agencies should open a Word document and write a budget narrative following the instructions in this document.*

Step 4 – Repeat Step 3 for each additional Service Category

Agencies must submit a separate Service Category narrative response, service units table, budget forms, and budget narrative for each program as described in each Service Category Packet

Step 5 – Complete the Checklist

Use the Checklist at the end of this document and double check to ensure you have included all the necessary forms, responses, and signatures as indicated in the RFA.

NARRATIVE RESPONSE QUESTIONS

Write a **Narrative Response** in a separate Word document for Sections A through D (below). Answer each section question thoroughly and completely.

Formatting Instruction:

1. Narrative documents should be submitted in letter-sized (8 ½ x 11-inch) format. Please use one-inch margins, single spacing, and use either Arial, Calibri, or Times New Roman, in a minimum of 12-point font.
2. Each Service Category Packet narrative may not exceed a total of 5 pages. This does not include:
   - Service Units Table (Form1)
   - Program Budget Forms (Forms 2a and 2b)
   - Budget Narrative(s)
3. Agencies do not need to rewrite the questions. However, responses should reference the Section letter and number related to each question.

Do not exceed a total of five (5) pages per response in each Service Category Packet(s).

A. UNDERSTANDING CLIENTS *(10 POINTS)*

1. Population(s) to be served:
   a. Within PWH, describe the priority populations to be served using key characteristics such as:
      i. Health Disparities
      ii. Other Relevant Information and Demographics

2. What barriers prevent clients from accessing entitlements/benefits and other programs that help clients access core and support services? Please explain both client level and systemic challenges.
   a. What is your program doing to mitigate and/or eliminate these barriers?

Rating Criteria – A strong application meets all criteria listed below.

- Applicant demonstrates a strong understanding of the priority population(s) demographics and health disparities.
- Applicant response demonstrates a strong understanding of both client and systemic barriers to care.

B. PROGRAM DESIGN/DELIVERABLES *(25 POINTS)*

1. Please provide a thorough description of your **Non-Medical Case Management** – **Engagement and Retention** program, including where and when services are provided and by whom.
   a. Include how your program assesses client needs/goals to ensure clients are linked to services funded by Ryan White and non-Ryan White providers.

2. How does your program maintain knowledge and expertise around entitlements/benefits, and other programs that specifically help clients achieve positive health outcomes and a better quality of life?

3. Describe how your **Non-Medical Case Management** – **Engagement and Retention** program:
   a. Ensures clients continued engagement.
   b. Contributes to retention in medical care.

c. Supports improved viral load suppression.

Rating Criteria – A strong application meets all criteria listed below.

- Applicant provides a thorough description of an innovative program that includes an understanding of eligible activities and evidence of client centered care.
- Applicant response indicates strong knowledge and expertise needed to provide high quality services that ensure clients get the care they need.
- (As applicable) Applicant response demonstrates likelihood of achieving improved client care, engagement in care, and health outcomes.

C. PARTNERSHIPS/COLLABORATIONS *(15 POINTS)*

1. How does your **Non-Medical Case Management - Engagement and Retention** program fit within the System of Care for PWH?
    a. Describe your referral relationships and list your partners.
    b. What gaps (in services that are not provided at/by your agency) do these partnerships address?

D. NEW PROGRAM INFORMATION REQUEST *(Unscored Technical Review)*

1. Are you applying to become a **<u>new</u>** Ryan White provider <u>in this Service Category</u>? If yes, please provide a narrative start-up timeline. (start-up timeline does not count toward 5-page limit)
    a. Consider the following elements:
        i. Program design, staff recruitment, policies and procedures, agency infrastructure, and when services will begin.
    b. Describe your agency's experience designing and implementing new programs.
    c. What challenges do you anticipate when starting this new program and how does your agency plan to develop the necessary expertise needed to address them?
    d. What partnerships/collaborations will strengthen this program?

Rating Criteria – A strong application meets all criteria listed below.

- Applicant response demonstrates existing collaborations and/or understanding importance of partnerships and collaborations.
- Applicant response demonstrates understanding of foreseeable gaps in care for their client population and necessary partnerships to address client needs.

INSTRUCTIONS FOR FORM 1: SERVICE UNITS TABLE

Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The first tab in this spreadsheet is Form 1 -Service Units Table. Form 1 - Service Units Table is an Excel spreadsheet that contains necessary information to complete the form. Some cells are locked to ensure they are not inadvertently written over or deleted.

Complete the Service Units Table form with unduplicated client counts and service units to be provided by the proposed program. This table should represent a summary of information from the Program Narrative section of the application and will form the basis of the contract for funded proposals.

Total Unduplicated Clients in Program refers to the total number of clients served by the program during the contract period. For programs that provide more than one service unit, Total Unduplicated Clients refers to all clients receiving services from the program, regardless of how many individual types of services the client(s) may use within the overall program (i.e., a client may use more than one service of that program). They would be counted as an unduplicated client within each specific service unit, but only as one client for the Total Unduplicated Clients in Program.

Service Units/Unduplicated Clients: Service Units for each category are listed and defined in each Service Category in the Directives, Definitions, and Service Units document. Your proposed program may offer any or all the service units listed in the category in which you are applying. Specify which of the service units your program proposes to provide.

Unduplicated Clients refers to the actual number of clients to whom the service units will be provided.

<u>How to complete this form</u>

Populate Column C: Funded by This Request
Enter the number of Service Units for Ryan White Part A eligible clients in Column C. If you do not intend to provide a particular Service Unit, enter zero (0). In the row below each Service Unit, enter the number of unduplicated clients receiving that service. Service Categories that require unduplicated client counts by Service Unit are indicated on Form 1 in each Service Category Packet. If a Service Category does not require unduplicated client county by Service Unit, agencies need only to provide Unduplicated Clients in Row 9.
Column C will only reflect the number of clients and service units that will be funded by Ryan White Part A.

Populate Column D: Total Program
Enter the number of total units/clients for the *total* program operating in the TGA. This column will reflect clients funded by this request *as well* as clients served by other funding. If funding requested under this proposal is the sole source of funding for your entire program, the numbers in Column D should match the numbers in Column C.

INSTRUCTIONS FOR FORM 2A: BUDGET – PERSONNEL BUDGET

Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The second tab in this spreadsheet is Form 2A – Personnel Budget. Form 2A – Personnel Budget is an Excel spreadsheet that contains formulas necessary to complete the form. Cells with formulas are locked to ensure they are not inadvertently written over or deleted.

Subtotals and Totals will automatically be calculated for all rows and columns. This budget must cover the Budget Period of March 1, 2025 – February 28, 2026. If this request is for a new program or expansion of an existing program, start-up delays may be likely and, if so, should be reflected in your request. The totals from Form 2A – Personnel Budget will automatically populate the Personnel and Fringe totals on Form 2B – Program Budget.

Personnel expenses must be related to client services in order to receive funding as a personnel line item. Examples include: The portion of a supervisor's time devoted to providing professional oversight and direction regarding RWHAP-funded core medical or support service activities, sufficient to assure the delivery of appropriate and high-quality HIV care to staff providing services to RWHAP clients is eligible; a portion of medical billing staff time related to RW clients; and the portion of the receptionist's time providing direct RW client services. For staff positions that are not related to direct service delivery, personnel costs must be included under administrative expenses/indirect costs. Personnel costs not related to direct service delivery must be included in the 10% administrative/indirect cost cap.

Salary Limitation:
Federal law limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is currently $221,900. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subcontracts under a HRSA grantor cooperative agreement.

The information provided on this form applies *only* to the proposed program described in this application, not to the whole agency.

List all staff employed directly by the agency to provide services specified in this program. Be sure to allow for normal delays in hiring, assuming that you will receive notice of the award by approximately December 24, 2024. **Include all personnel who are part of this program but are fully funded by other sources.**

NOTE: The Personnel Budget contains 18 rows for staff. If the program employs more than 18 staff, you may "Unhide" rows 29 through 54 by selecting both rows 29 and 54. Once they are selected, right click and the "Unhide Rows" options is available.

For each position **in the program**, complete the following:

Funded by Ryan White Part A

Column B **Position Title:** Descriptive job title used by the agency (be precise)

Column C & D **Last Name/First Name:** Enter the employee's Last and First name in these columns if the position is currently filled. If not currently filled, please write "TBD."

Column E **Annual Base Salary:** Enter the salary based on full-time employment. If this is not a full-time position in your agency, *project* the salary to full-time. Calculate all Cost-of-Living Adjustments

(COLAs) and step increases into this amount.

Column F **Begin Month:** Using the drop-down menu, select the first month of employment. If the program is established and positions are filled, enter March 2023. If this is a new program, or positions are not currently filled, enter the projected first month the employee will begin employment.

Column H **% Year:** This column will automatically populate based on the Begin Month from column E.

Column I **Portion FTE:** Using your agency's definition of what constitutes a full-time work week, calculate the percentage of time this staff person will be **funded by Part A** during the funding period, e.g., full-time, half-time, etc. Use decimal equivalents (e.g., full-time = 1.0, half-time = 0.5, etc.).

Columns J & K **Annualized FTE** and **Total Part A:** These columns will automatically populate from data entered in previous columns.

Funded by Other Sources

Column M **Portion FTE:** Using your agency's definition of what constitutes a full-time work week, calculate the percentage of time this staff person will be funded by **Other Funding Sources** during the funding period, e.g., full-time, half-time, etc. Use decimal equivalents (e.g., full-time = 1.0, half-time = 0.5, etc.)

The remaining columns (N, O, and P) will automatically populate based on the information provided in previous columns.

Lines 56 & 69 **Fringe @ _____%:** Provide the exact percentage, carried to two decimal places (e.g., 21.00%, 23.46%, etc.) **If your agency has more than one fringe rate, please provide the average rate for staff in the application.**

IMPORTANT NOTE: Fringe benefit rate is set at a default of 20%. This cell should be revised to reflect agency's current fringe benefit rate.

Line 71 **TOTAL PERSONNEL:** This cell will auto-populate

INSTRUCTIONS FOR FORM 2B: BUDGET – PROGRAM EXPENSES

Download the NMCM MAI Black Forms 1, 2A, 2B spreadsheet. The third tab in this spreadsheet is Form 2B – Program Expenses. Form 2B – Program Expenses is an Excel spreadsheet that contains formulas necessary to complete the form. Cells with formulas are locked to ensure they are not inadvertently written over or deleted.

*The Program Budget should include **all** expenditures for the proposed program, including expenses supported by other funding sources. For each line item, enter the amount requested in Column D that is being requested in this application for this program. In Column E, enter the amount of funds from other sources that support this program. If no other funding supports this program, enter "0" (zero) in Column E. Column F should be the total of Columns D and E.*

DIRECT EXPENSES

Per HRSA Part A Fiscal Monitoring Standards, a direct expense is any cost that can be specifically associated with *direct* client care. Direct costs include, but are not limited to, personnel, travel/mileage, equipment and supplies that directly benefit the project or activities defined in your Program Narrative. Below are some examples of traditional and typical Direct Expenses.

Line 10 - Total Personnel: These cells will automatically populate the amount from the Personnel Budget.

Line 14 - Travel/Mileage: Costs of program-related travel (*local travel only*) for staff or volunteers.

Line 15 – Supplies: Cost of supplies (client file folders, notebooks, paper, etc.) to be used specifically in relation to this program.

Line 16 - Telecommunications: Cost of telecommunication for direct client care. This includes internet, phone, and other technology used to communicate with clients.

Line 17 - Occupancy: Cost of rent, utilities, and other direct facility expenses allocable to Part A direct client care.

List other specific expenses directly attributable to this program, e.g., interpreter services, brochures, etc.

Line 31 and 32 will automatically calculate the sum of all Direct Expenses, including Personnel.

INDIRECT or ADMINISTRATIVE EXPENSES

INDIRECT EXPENSE

If awarded funds, agencies requesting Indirect Expenses will be required to provide detailed information about which costs are included in this rate and show that these costs are not also included in the Direct Expense categories.

Indirect costs are only allowable if:

1) Your agency has a **Federally Negotiated Indirect Rate (FNIR)** and submits documentary verification with this application. The maximum allowed under Ryan White is 10% regardless of the negotiated rate. Note: If your agency has an FNIR, it **must** be used for this grant.

OR

2) Your agency has NEVER had a FNIR and elects to use a 10% de minimis rate. Once elected, this rate must be used consistently for ALL awards of Federal funds. It will apply to the 10% of the Modified Total Direct Cost (MTDC) of the contract and must remain in effect until the subrecipient chooses to negotiate a rate (agency cannot choose to use 10% of the program budget hereafter).

INDIRECT EXPENSES

Line 34- FNIR: If your agency has an approved and current FNIR, use the drop-down menu in cell C34 to select "Yes". This will populate the Indirect Expense in Column D for the application.

Line 34 - De minimis: If your agency elects to use the de minimis rate, use the drop-down menu in cell C35 to select "Yes". This will populate the Indirect Expense in Column D for the application.

ADMINISTRATIVE EXPENSES

If the agency does not use an Indirect or De Minimis Rate, the agency may itemize Administrative Expenses on Form 2A and Form 2B.

Per HRSA Part A Fiscal Monitoring Standards, sub-recipient administrative activities include:

1. Usual and recognized overhead activities, including rent, utilities, and facility costs;

2. Management oversight such as program coordination, clerical, financial, and administrative staff **<u>not directly related to client care</u>**. (This is entered on Form 2A)

3. Computer hardware/software **<u>not directly related to client care</u>**, and audits; and

4. Other types of program support such as quality assurance, quality control, and related activities, except those related to your Ryan White Quality Management Plan.

All costs must be reasonable and necessary. In the Budget Narrative, provide an explanation of what your program/agency considers to be administrative expenses and the method by which those costs are allocated to the program. (See Budget Narrative Instructions) As stated in the Ryan White Act, funded programs "shall not use an excess of 10% of amounts received for administration."

Lines 40 through 56 – Administrative Expenses: Specify each of the items for which you are claiming administrative expenses. **Sub-recipients will be expected to provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements with each monthly invoice.**

Line 58 - TOTAL ADMINISTRATIVE EXPENSES: This line will automatically populate the sum of all lines on which you have itemized Administrative Expenses as well as any Administrative Personnel Expenses from Form 2A.

TOTAL PROGRAM EXPENSES

Line 59 - **Total Program Expenses:** This cell will automatically generate the sum of the separate categories of potential program funds (Total Direct Expenses (Line 32); Total Administrative Expenses (Line 58) or Total Indirect Costs (Line 34 or 35). Column D should be the total amount of your request; Column E, the total of other funds supporting the program; and Column F, the total program budget (sum of Columns D and E).

INSTRUCTIONS FOR BUDGET NARRATIVE

Write a **Budget Narrative** in a separate Word document for each line-item expense on Forms 2A and 2B. Provide a brief narrative detailing a) how the item relates to the proposed service, and b) the methodology used to determine the specific cost and allocation to Ryan White. The information provided on this form **applies *only* to the proposed program expenses described in this RFA,** not to the whole agency.

*EXAMPLE: **Program Manager – J. Smith ($11,250)**: Under Ryan White Part A, the Program Manager works .25 FTE providing direct services to Ryan White eligible clients via telephone, email, and in-person sessions. This position ensures client access and referrals to appropriate HIV health care, education, public assistance, financial assistance, and prescription resources, as part of patient-centered care. Please refer to Form 2A for detailed Personnel Expenses.*

*EXAMPLE: **Travel/Mileage – ($189):** Covers reimbursement for mileage and parking expenses incurred when conducting home visits, outreach, and other client contacts related to non-medical case management activities. Staff mileage reimbursement is at the IRS rate, currently $0.67 per mile. 200 miles x .67 per mile = $134; Parking @ $13.75/day for 4 days = $55.00; $134.00 + $55.00= $189.00.*

Personnel: Provide the titles of positions, and a brief description of the duties and responsibilities of the position in relation to the services outlined in this proposal. The description of duties and responsibilities must include how the position is categorized as either direct or administrative expense. For additional guidance, please refer to Attachment D and/or Policy Notice 15-01 and the FAQ for PCN 15-01, which can be accessed here: http://hab.hrsa.gov/manageyourgrant/policiesletters.html

Fringe: Provide a breakdown of the components that constitute the fringe benefits rate (i.e., medical, dental, workers' comp, etc.).

Travel/Mileage: Describe the travel that is anticipated during the budget/contract period. Be specific as to who is traveling, for what purpose and where they are traveling. Explain how mileage and other travel components were determined. *Only local travel directly attributable to the proposed program and program staff is allowable under this request.*

Equipment: List the items of equipment to be purchased and the purchase price. Describe why the equipment is necessary and who will use the equipment. A purchase versus lease analysis should be done for large dollar items.

Supplies: Provide a general description of the types of items classified as supplies.

Other: This category may include items such as printing or duplicating, telephone, FAX charges, and mail and postage costs. An amount and description must be provided for each cost item identified in this category.

Administrative Expenses: Specifically identify each line-item component claimed as part of Total Administrative Expenses. Provide an estimate of cost by line item. Describe the methodology used to determine the expense and to allocate it to this program. For example, describe how your agency decides to prorate rent by square footage costs and FTEs.

Subcontract: Briefly describe who the subcontractor is, what service they are providing, at what cost, and why. Describe what goals will be achieved through this collaboration and delineate the roles and responsibilities of each participating entity. Attach categorical budgets, with the same level of detail described for Direct and Administrative Expenses, for each subcontract.

SUBMISSION CHECKLIST

Agencies are strongly encouraged to utilize this checklist to ensure conformity with the application requirements and to ensure a complete application is submitted in a timely manner.

- ☐ Signed RFA Response Cover Sheet
- ☐ One Agency Information Packet (includes the following)
  - ☐ Narrative Response
    - Does the document conform with the formatting and font requirements?
    - Does the written response adhere to the five-page limit?
  - ☐ A copy of your agency's most recent financial statement or audit. (If agency is not required to complete an audit or financial statement, provide a copy of your most recent 990 Form.)
  - ☐ New applicants should include a copy of the agency's certificate of nonprofit status
- ☐ Service Category Packet(s) (Includes the following)
  - ☐ Narrative Response
    - Does the document conform with the formatting and font requirements?
    - Does the written response adhere to the five-page limit?
  - ☐ Service Units Table
    - Are the number of clients and service units reasonable considering the narrative response?
  - ☐ Personnel Budget
    - Have you included all staff that will work in the program?
    - Do all salaries comply with Federal limits?
  - ☐ Program Expenses
    - Are the program expenses reasonable and customary?
    - Did you include all other funding for the program?
  - ☐ Budget Narrative
    - Have you explained the method to calculate cost as well as how they are allocated to Ryan White Part A?
    - Have you provided a narrative for each expense listed on Form 2B, Program Expenses?

HRSA CATEGORICAL DEFINITIONS, PLANNING COUNCIL DIRECTIVES, AND SERVICE UNITS

In accordance with the prioritization process conducted by the Seattle TGA HIV/AIDS Planning Council, PHSKC will award funding within the following legislatively defined care service categories for budget period March 1, 2025 – February 28, 2026.

Non-Medical Case Management – MAI Black: - $188,896

This attachment includes:

- The HRSA and Planning Council-approved service category *definitions*, including types of activities allowable for funding under this service category.
- Planning Council-approved *service units* that applicant agencies should use in describing their proposed programs and in completing Form 1 (Proposed Service Units).
- Planning Council-identified *funding sub-priorities and directives* (where applicable), based on review of needs assessment data. Proposals that most effectively address these sub-priorities and directives will receive funding priority.
- HRSA *policy statements* (where applicable).

Seattle TGA HIV Planning Council Directives for All Service Categories:

Directive: Agencies must create a prioritization plan when demand exceeds funding. This would include cost containment measures. Prioritization should include overall health acuity, income, and disparities in underserved populations (Examples include race, gender, ethnicity, justice involvement, housing status, etc.). There is a process for when and how the policy is implemented.

Directive: Agencies have a mechanism for identifying and addressing health **disparities, implicit bias, barriers to access, including but not limited to physical barriers, knowledge** barriers, transportation barriers, and psychological barriers, and uses the information to improve service delivery.

Seattle TGA HIV Planning Council Directives for Non-Medical Case Management MAI Black:

Directive: Prioritize services for people who have disproportionate access to care and disparate health outcomes such as foreign-born Black people and Black trans women.

HRSA Categorical Definition and Planning Council Allowable Service Units:

HRSA CATEGORICAL DEFINITION: Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients 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, Pharmaceutical Manufacturer's Patient 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 face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan

- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

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

Minority AIDS Initiative (MAI) funding must be used to provide services to disproportionately affected communities of color to ensure engagement and retention in care, and ultimately, viral suppression. MAI funds must be used to provide enhancements to existing services for minority populations.

Service Units:

1. **Face-to-Face Encounters-Field (measured in 15-minute increments):** Encounters with clients outside of the agency office. Travel time to and from encounters is included in calculating time spent.
2. **Face-to-Face Encounters-Office (measured in 15-minute increments):** Encounters with clients in person at the agency office.
3. **Telephone Encounters (measured in 15-minute increments):** Encounters with clients via telephone.
4. **Written Communication Encounters (measured in 15-minute increments):** Encounters with clients via email, text or mail.
5. **Collateral Contacts (measured in 15-minute increments):** Work performed on behalf of a client to include making contact with another person or agency.

STANDARDS OF CARE

These are the most recent Standards of Care at the time of this RFA release. The Seattle TGA HIV Planning Council reviews and revises standards of care throughout each grant year. Consequently, the Standards of Care in this RFA are subject to change during the project period.

All Ryan White funded agencies must adhere to the Standards of Care developed by the Seattle TGA HIV Planning Council. Both the General Standards of Care and the Non-Medical Case Management Standards of Care apply to this Service Category.

The Seattle TGA HIV Planning Council reviews and revises standards of care throughout each grant year. When changes are made, sub-recipient agencies are notified and have 30 days to implement any changes needed to comply with the newly updated Standards of Care.

Seattle TGA Ryan White Part A Program General Standards

All subrecipients of Part A Funding in the Seattle TGA, with the exception of Early Intervention Services funding, are expected to meet the following General Standards. In certain instances, exceptions may be made to individual standards based on agency staff size, funding and/or the nature of the service provided. Any exception to compliance with one or more of the standards must be approved in writing by Public Health – Seattle & King County grantee within one month of contract execution.

1.0 Agency Licensure

	STANDARD	MEASURE
1.1	The agency has all appropriate licensure/accreditations.	Evidence of licensure and/or accreditation

2.0 Policies and Procedures

	STANDARD	MEASURE
2.1	The agency has developed and implemented the following policies and procedures: ▪ Case closure ▪ Client feedback mechanism ▪ Client education about complaints and grievances and the difference between them. ▪ Comprehensive assessment for each service category for which the agency receives Part A funding that complies with the service category's standards of care ▪ Grievance, including communicating the final disposition of the grievance to the grieving party. ▪ HIPAA ▪ Intake and referral process ▪ Mandatory reporting requirements related to abuse, neglect, and any harm to self or others ▪ Physical safety of staff and clients ▪ Program Evaluation ▪ Supervisory policies and structures ▪ Response time to client requests/contact	Procedures written and on file Recipient review reflects staff (and client, as appropriate) understanding and adherence to agency procedures. Recipient will review all grievances and assure that the process was followed through to completion.

	▪ Service plan for each service category for which the agency receives Part A funding that complies with the service category's standards of care ▪ The agency has a policy that indicates that they will provide services regardless of an individual client's ability to pay for the service. ▪ The agency has a policy to provide services regardless of the current or past health condition of the individual to be served. ▪ The agency has a policy that ensures veterans receiving Veterans Affairs health benefits are considered uninsured, thus exempting veterans from "payer of last resort" requirement. ▪ The agency has a policy regarding prioritization of services based on available funding and the policy is reviewed and revised as needed. The policy should include: • Disparities in underserved populations o Examples include: race, gender identity, ethnicity, justice involvement, housing status, etc. • Overall health acuity • Income	
2.1	The agency has the following agency/client level policies, and follows the policies. The agency ensures that clients and staff are informed of policies that affect them. There is documentation that they were discussed with clients: ▪ Eligibility ▪ Release of information (ROI)/informed consent ▪ Appropriate Professional Behavior & boundaries to include sexual harassment ▪ Scope of Services available at the agency ▪ Case Closure Criteria The agency has the following agency/client level policies, and follows the policies. They are discussed with clients, and there is documentation that they were discussed with clients. They are also posted at the agency in a location accessible to clients and staff: ▪ Client rights & responsibilities, including behavioral expectations ▪ Complaints and Grievances ▪ Confidentiality/limits of confidentiality	Written policies on file, evidence that they are being followed through Recipient's use of their monitoring tool.
2.3	The agency has a policy for client enrollment into programs or services. Unless otherwise noted in the Service Category standards of care, the policy will include all three elements of program enrollment listed below. 1. Client Intake (Intake) 2. Comprehensive Assessment (Assessment) 3. Individual Service Plan (Service Plan or ISP) • A Client Intake is the process of reviewing policies, procedures, and requirements for enrollment and completing all the necessary paperwork to	

	document those activities. To comply with this requirement, the agency will: o Complete the Intake within 5 days of receiving a referral or inquiry. o Review all policies in section 2.1 with client, as well as any agency policies and procedures. The agency documents this process in the Provide database with a client signature or an attestation that policies were reviewed with the client. o Obtain a signed Release of Information and Informed Consent from the client. o Conduct an Eligibility Assessment in the Provide database with or on behalf of the client. • A Comprehensive Assessment is completed every five years, or after any major life change. To comply with this requirement, the agency will: o Complete a Comprehensive Assessment within 30 days of completing an Intake. o Conduct a Comprehensive Assessment on certain life domains to determine client needs and barriers to treatment adherence and retention in care. The specific elements and life domains to be assessed are determined by the Comprehensive Assessment in each Service Category Standards of Care o Ensure the Comprehensive Assessment focuses on barriers that can be resolved by the Service Category o Provide a copy of the assessment to the client • An Individual Service Plan is completed at the time of enrollment and every six months thereafter. To comply with this requirement, the agency will: o Complete an Individual Service Plan within 30 days of completing an Intake o Work with the client to develop a mutually agreed upon Individual Service Plan to address and resolve needs and barriers identified in Comprehensive Assessment o Develop an Individual Service Plan that includes goals identified by the client, steps to achieve the goals, resources and referrals to help the client meet the goals, and target date for resolution o Review and update the service plan with the client every six months o Provide a copy of the service plan to the client	
2.7	The agency has an infection prevention and control plan. The plan must include at a minimum: • The implementation and use of the Center for Disease Control's Universal Precautions	Plan on file

	• A strategy for continuation of services and client communication • A plan to address emergent communicable diseases such as COVID-19	
2.8	The agency ensures that the facility is neat, clean, and free of clutter, hazardous substances, or other obstacles that could cause harm.	Physical observation by Recipient
2.9	The service facility is accessible to all individuals with HIV (the agency complies with the Americans with Disabilities Act and ensures that the facility is accessible by public transportation or provides transportation assistance).	Physical observation by Recipient
2.91	The agency has developed and implemented a procedure to communicate staff and program changes to staff and clients.	All providers must maintain documentation of communications in client files. Recipient review reflects staff understanding and adherence to this procedure.

3.0 Client and Service Eligibility

	STANDARD	MEASURE
3.1	The agency utilizes Ryan White Part A funding for clients as funding of last resort, as is required by the Health Resources and Services Administration.	Documentation of attempts to locate and utilize non-Ryan White funding streams for clients. When similar services are available, documentation demonstrates appropriate use of Ryan White funds (e.g., when the service is not adequate/appropriate for PLWH, or there are barriers to accessing other services in a timely manner, such as waitlists).
3.2	Clients are: ▪ HIV+ (Early Intervention Services clients do not need to know their status) ▪ At or below 500% Federal Poverty Level for all services ▪ There is no income eligibility for Early Intervention Services ▪ Residents of King, Island, or Snohomish counties ▪ Have no other third-party payer (insurance, Medicaid, etc.) for services they are seeking at the agency	All providers must maintain documentation of client eligibility in client files. Support service categories may document client eligibility by obtaining signed verification with supporting documentation from the case manager verifying client's eligibility for Ryan White services.
3.3	Ryan White program eligibility is assessed annually.	All providers must obtain annual documentation of clients' income, residence and insurance documentation verifying client's eligibility for Ryan White services using the eligibility assessment function in the statewide database.

4.0 Service Documentation

	STANDARD	MEASURE
4.1	Client records are kept in a locked/secure location.	Physical observation by Recipient

4.2	Services are documented in a way another care worker at the agency could provide continuity of care in an emergent situation.	Review of chart documentation
4.3	The agency makes every effort to work with the client to ensure continuity of care with all providers serving the client.	Review of chart documentation
4.4	For ongoing release of client information, agencies must verify that the entity to which information is being released is included on the signed Release of Information (ROI) in the client's file. In instances where the client is unable to sign the ROI, verbal consent by the client is documented by the staff on the ROI. Client refusal to sign the ROI must also be documented on that form.	Chart review by Recipient
4.5	Each ROI is consistent with current WAC legislation.	Chart review by Recipient
4.6	In instances where consent is provided for a one-time sharing of information, this will be documented in the client record with details about why the consent was needed.	Chart review by Recipient

5.0 Personnel

	STANDARD	MEASURE
5.1	In the recruitment of personnel, the agency is encouraged to use best practices to prioritize diversity, inclusion, and lived experience to ensure the best outcomes possible for the population they serve. Some best practices include using neutral and inclusive language in postings, using a diverse range of recruitment platforms, and creating an accessible website.	Review of job descriptions and personnel
5.2	All staff and volunteer positions have job descriptions.	Job descriptions are consistent with agency policies and exist for all staff and volunteer positions. All staff and volunteers have signed job descriptions in their personnel/volunteer files.
5.3	Program personnel have licensure/certification/registration as required for their position.	Review of personnel credentials against those recognized by WA state as valid for their profession/position.
5.4	Program staff licenses/certifications/registrations are current.	Copy of current license/certification/registration in personnel file
5.5	The agency ensures that staff who have close, direct, in-person client contact are tested upon hire and have an annual tuberculosis (TB) test.	Documentation of staff TB test or referral for TB test
5.6	The agency conducts a criminal background check of staff & volunteers, as per WAC guidelines and hiring decisions should not exceed WAC requirements.	Copy of criminal background check in personnel file
5.7	When searchable databases exist, the agency screens applicants for actions taken by state/local licensing bodies (WA DOH Health Systems Quality Assurance website).	Documentation of database search in personnel file
5.8	All personnel receive an annual performance evaluation.	Performance evaluations in personnel file

6.0 Staff Training

	STANDARD	MEASURE

6.1	Staff, within 30 days of hiring, and volunteers, within 30 days of placement, as appropriate to level and type of client contact, are trained in the following areas: • HIV/AIDS basics to include Universal Precautions • Job responsibilities • Legal reporting & disclosure • HIPAA (must be completed within 30 days of hire and then on an annual basis) • Documentation & record keeping • Professional boundaries* • Agency Policies* • Physical Safety policies* • Provided with copy of agency organizational chart, which includes the new employee	Documentation in personnel/volunteer file. * = Agency should be able to justify when the training was not needed for the position.
6.2	Staff, within 3 months of hiring, and volunteers, within 3 months of placement, as appropriate to level and type of client contact, are trained in the following areas: • Functional knowledge of HIV issues, to include epidemiologic trends, comorbidities, basics of treatment, basic psychosocial issues (to include mental health, substance abuse, housing issues, etc.) • TB and other infectious diseases • Crisis intervention • Infection control when applicable • Continuum of Care	Documentation in personnel/volunteer file. * = Agency should be able to justify when the training was not needed for the position.
6.3	Staff, within 6 months of hiring, and volunteers, within 6 months of placement, and on an ongoing basis, are trained in the following areas: • Mental health first aid • Equity and social justice • Trauma informed care • Culturally and linguistically appropriate policies and practices	Documentation in personnel/volunteer file. * = Agency should be able to justify when the training was not needed for the position.
6.4	The agency has a policy outlining core competencies specific to their services.	Policy on file
6.5	The agency provides access to continuing education needed to maintain skills/knowledge essential to job function.	Documentation of continuing education appropriate to staff position descriptions in personnel files
6.6	Agency personnel obtain the continuing education necessary to maintain licensure.	Staff licensure is current

7.0 Continuous Quality Management (CQM)

	STANDARD	MEASURE
7.1	The program engages in a CQM process.	Documentation of an agency/program committee engaged in ongoing QM projects
7.2	The program participates in Ryan White program Quality Management activities.	Program participates in Ryan White program QI trainings, activities, and QM reviews.
7.3	The program tracks their outcomes in helping clients access and stay in medical care and/or adhere to medications.	Reviewed on Quarterly QM progress reports
7.4	The agency has a mechanism in place for obtaining client feedback and documentation of its regular use.	Review of annual client feedback and agency response

7.5	The agency has structured and ongoing efforts to obtain input from clients in the design and delivery of services.	Reviewed on Quarterly QM Progress Reports
7.6	The agency has a mechanism for conducting program evaluations and uses the information from the evaluation process to improve service delivery.	Review of assessment and improvement efforts.
7.7	The agency has a mechanism for identifying and addressing barriers and using the information to improve service delivery. Barriers may include: • Physical barriers • Knowledge barriers • Health literacy • Cultural differences • Transportation barriers • Technology barriers • Behavioral health barriers	Year-end QM progress report and annual QM site visit The year-end QM Progress Report shall include a report of the results of agency's client feedback mechanism (client survey, focus group, community advisory boards, etc.). The client feedback mechanism must include questions related to barriers to access. A narrative on how this data was used to improve service delivery must also be included.

8.0 Coordination of Care

	STANDARD	MEASURE
8.1	The agency participates in HIV continuum-wide processes throughout the TGA.	Participation in needs assessments, provider work groups, and other committees that support the coordination of care.
8.2	The agency collaborates with other providers in the coordination of care.	Postings for other agencies' services in client waiting areas Documented referrals to/from other providers in charts
8.3	The agency has a process in place for locating current community resources for clients and educating clients about accessing those resources.	Site visit and documentation that process is in place
8.4	The agency has a process in place for promoting all available HIV services (within and external to the agency) to eligible individuals, especially those who are historically underserved.	Accessible forms of communication are observed at site visit

9.0 CLAS Mandates

The Culturally and Linguistically Appropriate Services (CLAS) standards were issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) in 2001 to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. OMH developed these standards to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. The CLAS standards include mandates (requirements for all recipients of federal funds), guidelines (activities recommended by OMH for adoption by Federal, State and national agencies), and recommendations (suggestions for voluntary adoption by health care organizations). The Seattle TGA HIV Planning Council has developed the following standards to help agencies meet the required four CLAS mandates (standards 4, 5, 6, and 7).

- *Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.*
- *Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.*
- *Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.*
- *Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.*

OMH uses the term “health care organizations” to identify the types of organizations for which CLAS standards were developed. “Health care organizations” are defined for this document as “all organizations that contract with Public Health – Seattle & King County to receive federal funding to provide care and services to people with HIV.”

The goal of these standards is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

	STANDARD	MEASURE
9.1	The agency has a language access plan. *A language access plan can help ensure that an organization provides high quality and appropriate language services. A language access plan can also help ensure that an organization’s staff members are aware of what to do when an individual with limited English proficiency needs assistance.*	Written plan in agency policies.
9.2	The agency provides to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	Agencies prominently display notification informing patients of their right to receive language assistance services at no cost to them Client intakes include information about the client’s preferred language.
9.3	Each client’s preferred language is reassessed every six months.	Documented in client chart
9.4	The agency offers and provides language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation. *Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an infrequently encountered language.*	All requests for interpretation services are documented in client charts, including language requested, date of request, nature of the service for which the language assistance is requested and the outcome of the request. If agencies are unable to provide and/or locate interpretation services for patients/consumers as requested, agencies document in client charts the means undertaken to refer patients/consumers to other agencies/providers who may be able to offer the service in the language preferred by the client. Agencies document active attempts to recruit staff and volunteers who are bilingual in English and commonly encountered languages of the service population through job postings and outreach efforts.
9.5	The agency ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals as interpreters should be avoided.	Documentation that bilingual staff passed a written test, were interviewed in each language, or were otherwise evaluated to

	Under no circumstances shall minor children be used as interpreters, nor shall they be allowed to interpret for their parents when they are the patients/consumers.	be competent to provide bilingual services. Documentation that interpretation was provided by certified interpreters/certified medical interpreters (for clinical visits) If a patient/consumer declines bilingual staff and/or outside interpretation, and instead chooses to use adult family members or friends to provide language assistance services, this declination is documented in the patient/consumers' chart and the consumer and the family/friend signed a release of information with the program staff.
9.6	The agency makes available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	Agencies post signage in their waiting rooms and/or at the reception areas in English and other languages commonly spoken by their service population to identify or label the location of specific services and amenities. Agencies make available patient-related materials (applications, consent forms, rights and responsibilities, and other written materials routinely provided to clients) in both English and other languages commonly spoken by their service population or as requested by the client.
9.7	The agency will create a culturally inclusive environment. • Lobby / reception area (décor, posters, images, literature, brochures, etc.) welcoming to and reflective of population(s) served.	Physical observation and client feedback.
9.8	The agency will educate and train governance and leadership in culturally and linguistically appropriate policies and practices on an ongoing basis.	Review of appropriate meeting minutes during site visit.

Seattle TGA Ryan White Program Standards

Case Management (Non-Medical)

Approved by Council on 7/10/2023

HRSA Definition

Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs,

Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, 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
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance

NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

Seattle TGA Definition, including sub-priorities:
The Seattle definition follows the HRSA definition in addition to information on the sub-priorities listed below.
Sub-priorities:

- Housing NMCM, including search and referral
- Dental NMCM
- Chemical Dependency NMCM
- Engagement and Retention in Care NMCM
    - Supports NMCM work that is not housed within an existing MCM program.

Service Units:

For all sub-priorities:

6. **Face-to-Face Encounters-Field:** Encounters with clients outside of the agency office. 15 minute increments. Travel time to and from encounters is included in calculating time spent.
7. **Face-to-Face Encounters-Office:** Encounters with clients in person at the agency office. 15 minute increments.
8. **Telehealth**: Encounters with clients via telehealth platform. 15 minute increments.
9. **Telephone:** Encounters with clients via telephone. 15 minute increments.
10. **Written Communication Encounters:** Encounters with clients via email, text or mail. 15 minute increments.
11. **Collateral Contacts:** Work performed on behalf of a client to include making contact with another person or agency. 15 minute increments.

For Housing NMCM Only:

12. **Client Housing Placement-Ryan White**: 1 Placement=1 Service Unit.

13. Client Housing Placement-Other Funding: 1 Placement=1 Service Unit.

1.0 General Standards

	STANDARD	MEASURE
1.1	Program adheres to Seattle TGA Ryan White Program General Standards	Part A site visit documents adherence

2.0 Staff & Volunteer Qualifications and Training

	STANDARD	MEASURE
2.1	Please refer to the General Standards 6.0 and 7.0. Specific sub-priority standards are listed below in the sub-priorities.	Part A site visit documents adherence

3.0 Sub-Priority 1: Housing Non-Medical Case Management, including Search and Referral

	STANDARD	MEASURE
3.1	The Agency/Non-Medical Case Manager will conduct an **Intake** within 5 working days following a referral or request for Non-Medical Case Manager-Housing services. The Intake will include: • Documentation of client needs for Non-Medical Case Management-Housing services • Documentation of the review of required policies (See General Standards 2.0) • Verification of client eligibility for Non-Medical Case Management-Housing and to conduct an Eligibility Assessment if the client does not have a current eligibility assessment in Provide. • Enrollment of the client into Non-Medical Case Management-Housing program at the agency	Client signed copy scanned and uploaded to Provide.

3.2	Within 30 days, the Non-Medical Case Manager will work directly with the client to conduct a **Comprehensive Assessment**. The Comprehensive Assessment is updated at any major life change or every five years. The Comprehensive Assessment for Non-Medical Case Manager-Housing will include an assessment of following life domains and barriers to housing, engagement in care, and viral suppression:
	
	• Housing history, strengths, barriers, and current housing needs
	• Type of housing/support needed for Activities of Daily Living (ADL) Independent Activities of Daily Living (IADL) or other disabilities
	• Type of housing barriers to assess include but are not limited to:
	    o Legal barriers to housing
	    o Intimate partner violence
	    o Mental Health
		Documentation in Provide client record

	◦ Substance use ◦ Finances, income, and employment ◦ Additional support needed for other resources (HOPWA, STRMU, PHP) and other vouchers • Engagement and retention in primary medical care and treatment adherence ◦ Current medical and case management providers • Need for supportive services and other basic needs • Language in which the client prefers to receive services	
3.3	The Non-Medical Case Manager will work with the client to develop **a mutually agreed upon Individual Service Plan** (ISP) to address barriers identified in the Comprehensive Assessment. The ISP will include: • Housing barriers identified in the Comprehensive Assessment • Housing Navigation including search and referral needs • Specific goals to overcome or address barriers to stable housing ◦ Actions to be taken by the client and Non-Medical Case Manager ◦ Target date for completion of each goal	Documentation in Provide client record
3.4	The Non-Medical Case Manager will re-evaluate of the Individual Service Plan with the client at least every 6 months to document progress on each goal and make adaptations as necessary.	Updated Individual Service Plan goals in Provide client record
3.5	Non-Medical Case Manager are expected to coordinate with Medical Case Manager(s), health care providers and other relevant service providers about the client and the client's current needs as appropriate and as allowed under HIPAA.	Documentation in Provide client record

4.0 Sub-Priority 2: Dental Non-Medical Case Management

	STANDARD	MEASURE
4.1	The Agency/Non-Medical Case Manager will conduct an **Intake** within 5 working days following a referral or request for Non-Medical Case Manager-Dental services. The Intake will include: • Documentation of client needs for Non-Medical Case Manager-Dental services • Documentation of the review of required policies (See General Standards 2.0) • Verification of client eligibility for Non-Medical Case Management-Dental and to conduct an Eligibility	Client signed copy scanned and uploaded to Provide.

	Assessment if the client does not have a current eligibility assessment in Provide. • Enrollment of the client into Non-Medical Case Management-Dental program at the agency	
4.2	Within 30 days, the Non-Medical Case Manager will work directly with the client to conduct a **Comprehensive Assessment**. The Comprehensive Assessment is updated at any major life change or every five years. The Comprehensive Assessment for Non-Medical Case Manager-Dental will include an assessment of following life domains and Oral Health/Dental factors: • Current oral health needs • Access to transportation • Current medical providers and case management providers • CD4 and viral load counts. • Language in which the client prefers to receive service • Other barriers (such as mental health, substance use, dental fears, etc.)	Documentation in Provide client record
4.3	Based on the Comprehensive Assessment, the Non-Medical Case Manager will appoint the client to the appropriate dental provider.	Documentation in Provide client record
4.4	Attempts to appoint new clients will be made within 30 days of enrollment in the program.	Documentation in Provide client record
4.5	Within 30 days of the initial appointment with dental service provider, the dental provider will develop a treatment plan, which will serve as the client's mutually agreed upon **Individual Service Plan**.	Documentation held at dental provider office and made available upon request.
4.6	Once the client is enrolled in the dental program, Non-Medical Case Manager provides appropriate follow up, as needed, to ensure the client is accessing oral health services.	Documentation in Provide client record

5.0 Sub-Priority 3: Chemical Dependency/Substance Use Non-Medical Case Management

	STANDARD	MEASURE
5.1	Staff providing direct service must have a current and active Substance Use Disorder Professional Certification and must adhere to all requirements outlined in the Revised Code of Washington (RCW) Chapter 18.205 and Washington Administrative Code (WAC) 246-811.	Client signed copy scanned and uploaded to Provide.
5.2	The Agency/Non-Medical Case Manager will conduct an **Intake** within 5 working days following a referral or request for Non-Medical Case Manager-CD services. The Intake will include:	Documentation in Provide client record

	• Documentation of client needs for Non-Medical Case Management-Chemical Dependency services • Documentation of the review of required policies (See General Standards 2.0) • Verification of client eligibility for Non-Medical Case Management-Chemical Dependency and to conduct an Eligibility Assessment if the client does not have a current eligibility assessment in Provide. • Enrollment of the client into Non-Medical Case Management-Chemical Dependency program at the agency	
5.3	Within 30 days, the Non-Medical Case Manager will work directly with the client to conduct a **Comprehensive Assessment**. The Comprehensive Assessment is updated at any major life change or every five years. The Comprehensive Assessment for Non-Medical Case Manager-Chemical Dependency will include an assessment of, at a minimum, the following life domains and barriers to substance use treatment, engagement in care and viral suppression: • History of substance use/prior treatment • Support system • All forms of employment and income • Housing • Mental Health • Intimate partner violence • Engagement and retention in primary medical care and treatment adherence o Current medical and case management providers • Need for supportive services and other basic needs • Language in which the client prefers to receive services	Documentation in Provide client record
5.4	The Non-Medical Case Manager will work with the client to develop a mutually agreed upon **Individual Service Plan** (ISP) to address barriers identified in the Comprehensive Assessment. The ISP will include: • Barriers to substance use treatment/harm reduction measure as identified in the Comprehensive Assessment • Specific goals to overcome or address barriers to treatment or harm reduction o Action to be taken by the client and Non-Medical Case Manager	Documentation in Provide client record

	◦ Target date for completion of each goal	
5.5	The Non-Medical Case Manager will re-evaluate of the Individual Service Plan with the client at least every 6 months to document progress on each goal and make adaptations as necessary.	Updated Individual Service Plan goals in Provide client record
5.6	Non-Medical Case Manager staff are expected to coordinate with Medical Case Manager(s), health care providers and other relevant service providers about the client and the client's current needs as appropriate and as allowed under HIPAA.	Documentation in Provide client record

6.0 Sub-Priority 4: Engagement and Retention in Care Non-Medical Case Management

	STANDARD	MEASURE
6.1	The Agency/Non-Medical Case Manager will conduct an **Intake** within 5 working days following a referral or request for Non-Medical Case Manager-Engagement and Retention services. The Intake will include: • Documentation of client needs for Non-Medical Case Management-Engagement and Retention services • Documentation of the review of required policies (See General Standards 2.0) • Verification of client eligibility for Non-Medical Case Management-Engagement and Retention and to conduct an Eligibility Assessment if the client does not have a current eligibility assessment in Provide. • Enrollment of the client into Non-Medical Case Manager-Engagement and Retention program at the agency	Client signed copy scanned and uploaded to Provide.
6.2	Within 30 days, the Non-Medical Case Manager will work directly with the client to conduct a **Comprehensive Assessment**. The Comprehensive Assessment is updated at any major life change or every five years. The Comprehensive Assessment for Non-Medical Case Manager-Engagement and Retention will include an assessment of following life domains and barriers to engagement in care and viral suppression: • Finances/benefits • Housing • Transportation • Legal Services • Substance Use • Mental Health • Intimate partner violence • Support system	Documentation in Provide client record

	• Engagement and retention in primary medical care and treatment adherence ○ Current medical and case management providers • Need for supportive services and other basic needs • Language in which the client prefers to receive services	

6.3	The Non-Medical Case Manager will work with the client to develop a mutually agreed upon **Individual Service Plan** (ISP) to address barriers identified in the Comprehensive Assessment. The ISP will include:
	
	• Barriers to Engagement and Retention as identified in the Comprehensive Assessment
	• Specific goals to overcome or address barriers to primary care, treatment adherence, support service, or other needs in the Comprehensive Assessment.
	  ○ Action to be taken by the client and Non-Medical Case Manager.
	  ○ Target date for completion of each goal
		Documentation in Provide client record

6.4	The Non-Medical Case Manager will re-evaluate of the Individual Service Plan with the client at least every 6 months to document progress on each goal and make adaptations as necessary.	Updated Individual Service Plan goals in Provide client record
6.5	Non-Medical Case Manager staff are expected to coordinate with Medical Case Manager(s), health care providers and other relevant service providers about the client and the client's current needs as appropriate and as allowed under HIPAA.	Documentation in Provide client record

7.0 Case Closure

	STANDARD	MEASURE
7.1	Please refer to the General Standards 2.1 wherein the agency follows its case closure policies.	Documentation in client record