RYAN WHITE PART B CLIENT SERVICES MANUAL

2016

Client Services Manual

Section 1 – Introduction

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1.0 Introduction

The HIV care continuum includes a complex network of medical and social service agencies that can be challenging for people living with HIV to navigate. In Iowa, PLWH face many barriers to navigating and accessing HIV care, such as transportation, stigma, and financial resources. Case managers and Ryan White Part B staff play a vital role in helping clients to navigate and access HIV care.

HIV case management exists in part to connect an often-fragmented system. It can serve as a catalyst for quality, cost-effective care by linking the patient, the physician, and other members of the care coordination team, the payer, and the community. Without the coordination provided by case managers, some clients can become confused about how the system works and frustrated by the time and effort involved. Consequently, many clients can become detached and ultimately disengage from care services. It is important to remember, however, that although the absence of case management can hamper client access to needed services, multiple case managers working in an uncoordinated system can contribute to the fragmented service delivery that case management is meant to alleviate. This is the reason why there is a new requirement that each case management program must develop detailed policy and procedure guidelines. Guidance can be found in Section 9.

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Ryan White Part B Services, which includes a multi-level, or tiered, case management system, as well as other support services, are provided in a variety of settings in Iowa. These settings include AIDS Service Organizations, health departments, and medical facilities. The Iowa Department of Public Health (IDPH) currently contracts with 10 agencies to provide Ryan White Part B Services. A list of those agencies can be found in Appendix A.

1.1 How to Use this Manual

This manual is intended to provide Part B providers with a clear understanding of Iowa's Ryan White Part B Program, standards of service, and requirements expected of all service providers.

The policies and standards outlined reflect a minimum standard of care that is essential to meet the needs of people living with HIV. Adherence to these policies and standards ensures quality services that are consistent and that can be evaluated for effectiveness.

The manual is divided into four main sections:

Section 1: Introduction: The introduction helps the reader to know how to use the manual, what services are offered in Iowa, some key terms, and the standards that are used to monitor services.

Section 2: Case Management: The case management section has two chapters: background and framework, and standards of care.

The background and framework chapter is essential reading for all new case managers and serves as an excellent reminder for seasoned case managers. It answers important questions, such as what case management is and why it continues to be important for PLWH. This chapter also lays out the overarching roles and responsibilities of a case manager in Iowa, and key ideologies and principles of the Iowa case management program.

The next chapter in this section describes in detail Iowa's four-tiered case management program, including core elements, standards, and other requirements for each tier.

Section 3: Other Core and Support Services: This section includes guidelines and requirements for other services that are, or could be, delivered by Iowa Part B providers. If your agency provides any of these services, or would like to, please refer to this section to ensure compliance with program requirements.

Section 4: Technical Issues: This section includes information about "payer of last resort," some overarching CAREWare guidelines, client fine maintenance, and policy and procedure requirements.

1.2 Services in Iowa

This section provides a brief overview of the service delivery system in Iowa. Services provided by Ryan White Part B, Ryan White Part C, and the Housing Opportunities for Persons with AIDS (HOPWA) program are reviewed.

Part B Services in Iowa

The Iowa Department of Public Health (IDPH) is Iowa's grantee for the Ryan White Part B Program. The grant consists of a base award, the AIDS Drug Assistance Program (ADAP) award (i.e., the ADAP earmark), and an optional ADAP supplemental award. The supplemental award requires a 3:1 (ADAP to state) match.

In addition to case management services, Iowa's Ryan White Part B program may provide funding to cover core medical services, including:

- Outpatient and ambulatory health services;
- ADAP;
- Oral health care;
- Early intervention services;
- Health insurance premium and cost-sharing assistance;
- Medical nutrition therapy;
- Mental health;

- Outpatient substance abuse care; and
- Treatment adherence services.

Support services funded through Part B may include:

- Outreach services;
- Psycho-social support;
- Medical transportation;
- Linguistic services; and
- Referrals for health care and support services.

For a full list of Part B core and support services refer to Appendix A.

The IDPH contracts with 10 agencies (referred to as Part B providers) to provide case management and other core and support services throughout the state. Part B providers deliver essential health and supportive services to financially eligible clients living with HIV. All Ryan White programs are "payers of last resort," meaning that all other resources, including Medicaid and Medicare, need to be exhausted before the Part B Program may pay for a service. In 2013, more than 1,100 PLWH received services through the Ryan White Part B Program.

For a full list of Part B providers refer to Appendix B.

Part C services in Iowa

Part C of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides grants directly to service providers such as ambulatory medical clinics to support outpatient HIV early intervention services and ambulatory care. The Part C Early Intervention Services component of the Ryan White HIV/AIDS Program funds comprehensive primary health care in an outpatient setting for PLWH disease.

In fiscal year 2011, Iowa's Part C clinics received approximately $1.6 million in Ryan White Part C funding and were able to provide the following services to over 1,200 patients:

- Risk-reduction counseling, antibody testing, medical evaluation, and clinical care;
- Antiretroviral therapies; protection against opportunistic infections; and ongoing medical, oral health, medical nutritional therapy, psychosocial, ophthalmology, and other care services for HIV-infected clients;
- Case management to ensure access to services and continuity of care for HIV-infected clients; and
- Support services, such as linguistic services, testing and treatment for tuberculosis, and services for treatment of substance abuse or mental health issues.

For a full list of Part C providers refer to Appendix C.

HOPWA services in Iowa

The Housing Opportunities for Persons with AIDS (HOPWA) Program provides housing assistance and related supportive services for low-income PLWH and their families to establish or maintain a stable living environment in housing that is decent, safe, and sanitary. HOPWA also works to reduce the risk of homelessness, and to improve access to health care. HOPWA services in Iowa are administered by the Iowa Finance Authority, which contracts with community-based organizations to deliver the services.

In calendar year 2013, HOPWA was able to provide the following services to over 200 individuals living with HIV:

- Short-Term Rent, Mortgage, & Utilities (STRMU): needs-based, time-limited housing assistance designed to maintain stable living environments for people who are experiencing a financial crisis and potential loss of their housing arrangement.
- Tenant-Based Rental Assistance (TBRA): used to help participants obtain permanent housing that meets housing quality standards at a reasonable rent in the private rental housing market.
- Supportive Services: a wide range of services that may include education, employment assistance, legal, life skills management, outreach, transportation, health, mental health assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, day care, personal assistance, nutritional services, intensive care when required, and assistance in gaining access to local, state, and federal government benefits and services.

For a full list of HOPWA providers refer to Appendix D.

1.3 Terminology

This manual contains terminology and acronyms that are specific to the Ryan White Program.

For purposes of this manual, please review the following entities, their role, and how they will be referred through the manual:

Centers for Disease Control and Prevention (CDC) is the federal agency that administers prevention funding for many diseases including HIV, sexually transmitted diseases, and viral hepatitis.

Clients are individuals living with or affected by HIV who access Ryan White Part B services through a Ryan White provider.

Department of Health and Human Services (HHS or DHHS) is the federal agency that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

Health Resources and Services Administration (HRSA) is an operating division of the DHHS that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

HIV/AIDS Bureau (HAB) the bureau within the HRSA that administers Ryan White funding appropriated by Congress through the Ryan White HIV/AIDS Treatment Extension Act of 2009.

Housing Opportunities for Persons With AIDS (HOPWA) is a federal program dedicated to the housing needs of people living with HIV/AIDS. HOPWA is administered by the U.S. Department of Housing and Urban Development.

Iowa Department of Public Health (IDPH) is the recipient in Iowa that receives Ryan White Part B funding to provide core and support services, including ADAP.

Iowa Finance Authority (IFA) is the state agency who administers Iowa's HOPWA funds.

Part B providers are agencies across the state of Iowa (and one in Nebraska) that provide direct Ryan White Part B services to Iowan's living with HIV. The IDPH contracts with Part B providers to make these services available (sub-recipient).

Part C providers are clinics that receive direct funding from HRSA to provide HIV medical care.

Ryan White HIV/AIDS Treatment Extension Act of 2009 is the largest federal program focused exclusively on HIV care. The legislation was first enacted in 1990 as the Ryan White CARE (Comprehensive ADIS Resources Emergency) Act. It has been reauthorized four times: in 1996, 2000, 2006, and 2009.

1.4 National Monitoring Standards

The National Monitoring Standards were created and implemented by HRSA to help Ryan White HIV/AIDS Program grantees and sub-grantees improve program efficiency and responsiveness. The standards define federal requirements and expectations for program and fiscal management, monitoring, and reporting.

Structure of National Monitoring Standards

There are three sets of standards:

1. **Universal Monitoring Standards** – covering both fiscal and program requirements that apply to Ryan White Part A and Part B programs.
2. **Fiscal Monitoring Standards** – separate versions for Part A and Part B.
3. **Program Monitoring Standards** – separate versions for Part A and Part B, with some specific AIDS Drug Assistance Program (ADAP) components.

Format

Each set of Standards has four related components. They include:

Performance measures and methods for determining whether the standard is being met – actions to take and data to collect and analyze.

Grantee responsibility for meeting each standard – suggested actions and data requirements for the grantee. In Iowa, the Grantee is IDPH.

Provider/sub-grantee responsibility for meeting the standard – suggested actions the provider/sub grantee should be expected to take and data to be collected and maintained. In Iowa, the Provider/sub grantees are the 10 agencies who provide direct Ryan White Part B services (referred to as Part B providers). For a complete list see Appendix A.

Citations that provide the source for each standard – legislation, federal regulations, federal (e.g., HRSA HAB) policy, and guidance – so users are able to find and review the source document that specifies the requirement.

The IDPH ensures that the Part B Program in Iowa meets the expectations outlined in the monitoring standards. It is also the responsibility of each Part B provider to read and understand the standards. To review the complete National Monitoring Standards, visit http://hab.hrsa.gov/manageyourgrant/granteebasics.html.

2.0 Case Management Background and Framework

Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's needs. The purpose of case management is to provide clients with continuity of care by assisting them with developing effective and comprehensive networks of care and support to meet their needs now and in the future.

Since the beginning of the HIV epidemic, case management has been the cornerstone of programs that seek to address a wide array of medical, socioeconomic, and psychological factors that affect the functioning and wellbeing of HIV-positive individuals. Through the years, case management has evolved, and different terms such as "service coordination," "support coordination," and "resource management" have also been used. As self-directed services and consumer control have increased, the role of support brokering – assisting individuals to self-direct their services – has also emerged. Service brokering involves directing people to needed services, coordinating payment for those services, and empowering the consumer to manage them.

Aspects of the service brokerage model, along with other case management models are incorporated into Iowa's Ryan White case management program. The program design has changed in response to unique local, organizational, and client factors. The principles of self-determination and self-direction have been deeply integrated into the program structure.

This section outlines the framework from which the Iowa case management model was developed and concepts to guide program development and to support the daily work of Iowa case managers.

2.1 What is Case Management?

Case management is a client-focused process that expands and coordinates, where appropriate, existing services to clients. Case management is also referred to as "program coordination" or "service coordination," phrases that reflect a more client-centered approach. In its simplest form, case management involves the referral of clients to providers of services, a situation in which case manager's act largely as broker agents. At the other end of the spectrum, intensive models feature care and support services that are co-located to address the broad array of client needs (the team-based approach), or empowerment strategies designed to build client core competencies (the strengths-based model). Given the range of approaches that exist under the mantle of "case management," there is considerable debate about whether case management is actually a profession, a methodology, or a group of activities. Some consider it more of an art than a science.

Despite the wide variations in practice, the overarching goal of case management is the same in all systems: to facilitate clients' autonomy to the point where they can obtain services on their own. While there are exceptions in some jurisdictions, in general, case managers do not provide direct services such as mental health therapy, substance abuse treatment, or legal assistance; rather, they assess a client's need for such services and arrange for them to be provided.

In general, case management is used to:

- Assess client service needs;
- Determine client eligibility for benefits and services and aid clients in applying for assistance;
- Coordinate support services and care from different providers to meet clients' needs;
- Implement disease management, which generally includes client education, counseling, client appointment and medication reminders, routine reporting to providers and clients, and other activities to promote quality of care while achieving cost efficiencies;
- Advocate for clients, and empower clients to advocate for themselves; and
- Provide supportive counseling (not therapy).

2.2 Why is Case Management Important for People Living with HIV? (Guiding Principles)

According to CDC, more than 1.2 million Americans are living with HIV, and approximately 14% (almost 1 out of every 7) are unaware they are infected with the virus. For those infected with the disease, the medical outlook is vastly different today than it was in the early days of the epidemic, when treatment was largely palliative, and life expectancies following diagnosis were relatively short. Today's treatments have transformed HIV from what was once an acute, fatal condition to a chronic, manageable disease. Individuals with the virus have the potential to live long, productive, fulfilling lives. However, many face barriers that prevent them from receiving the full benefit of available treatment options.

A high percentage of PLWH come from populations historically underserved by traditional health care systems. Many struggle with substance abuse problems, homelessness and mental illness. Men who have sex with men, youth, and people of color (men and women) are disproportionately affected.

Despite years of public awareness and education campaigns meant to dispel misconceptions about the disease, PLWH still experience stigma from society and within health care systems that can discourage them from seeking care. Further, HIV impacts individuals in multiple domains, including the biomedical, psychosocial, sexual, legal, ethical and economic. For those with access to long-term treatment, HIV medications can be very effective but may be accompanied by significant side effects that affect quality of life and add to the complexity of managing co-morbidities like substance abuse, mental illness, or other chronic medical conditions.

If HIV progresses to AIDS, the damage to the immune system makes clients more susceptible to opportunistic infections that may lead to greater need of acute care and hospitalizations. These episodes can be followed by periods of relatively good health, thus illustrating potential changes in a client's level of need over time.

Studies have found a high level of need for care and support services among PLWH. Research suggests that case management is an effective approach for addressing the complex needs of chronically ill clients.

Case management can help improve client quality of life, satisfaction with care, and use of community-based services.

Case management also helps reduce the cost of care by decreasing the number of hospitalizations a client undergoes to address HIV-related medical conditions. On the behavioral front, case management has been effective in helping clients address substance abuse issues, as well as criminal and HIV risk behavior.

Clients with case managers are also more likely than those without to follow their drug regimens. One study found that use of case management was associated with higher rates of treatment adherence and improved CD4+ cell counts among PLWH who were homeless and marginally housed. More intensive contact with a case manager has been associated with fewer unmet needs for income assistance, health insurance, home care and treatment. Recent studies have found that even brief interventions by a case manager can improve the chances that a person newly diagnosed with HIV will enter into care.

It is apparent that optimal care for HIV clients requires a comprehensive approach to service delivery that incorporates a wide range of practitioners, including doctors, mental health professionals, pharmacists, nurses, and dietitians, to monitor disease progression, adherence to medication regimens, side effects, and drug resistance. With regard to support services, most programs serving those with HIV provide or have referrals to HIV prevention programs, mental health counseling, substance abuse treatment, housing, financial assistance, legal aid, childcare, transportation and other similar services, both inside and outside HIV systems of care. Case managers perform a critical role in facilitating client access to and use of these services, in part, by ensuring they are well coordinated.

Case management services should reflect principles of service delivery that affirm a client's right to:

- A quality life
- Privacy
- Confidentiality
- Self-determination
- Freedom from discrimination
- Compassionate non-judgmental care
- Dignity and respect
- Culturally competent service delivery
- High-quality case management services.

2.3 Role and Activities of Case Manager

The primary activities of case management are to assess client needs and arrange services to address those needs. The way in which these activities are carried out is influenced by a variety of factors, including organizational mission, staff expertise and training, availability of other resources, and client need.

A broad variety of secondary activities can be included under the mantle of case management. On a systems level, these activities might include resource development, performance monitoring, financial accountability, social action, data collection, and program evaluation. On a client level, case managers may perform duties that include outreach/case finding, prevention/risk reduction, medication adherence, crisis intervention, health education, substance abuse and mental health counseling, and benefits counseling.

Despite these variations, a Federal Interagency HIV/AIDS Case Management Work Group identified six core functions that are common to most case management programs, irrespective of the setting or model used, based on their review of federally funded programs and case management research. While the emphasis placed on each function may differ across agencies according to organizational objectives, cultures, and client populations, they nonetheless comprise a foundation for the practice of case management. These core functions are listed below.

- **Client identification, outreach and engagement (intake)** is a process that involves case finding, client screening, and determination of eligibility for services, dissemination of program information, and other related activities. Intake activities may be based on client health status, geography, income levels, insurance coverage, etc. Case managers should deal with their clients in a culturally competent manner and maintain the confidentiality of their medical information, in accordance with privacy rules and regulations.

- **Assessment** is a cooperative and interactive information-gathering process between the client and the case manager through which an individual's current and potential needs, weaknesses, challenges, goals, resources, and strengths are identified and evaluated for the development of a treatment plan. The accuracy and comprehensiveness of the assessment depends on the type of tool used, the case manager's skill level and the reliability of information provided by the client.

- **Planning** is a cooperative and interactive process between the case manager and the client that involves the development of an individualized treatment and service plan based on client needs and available resources. Planning also includes the establishment of short-term and long-term goals for action.

- **Coordination and Linkage** connects clients to appropriate services and treatment in accordance with their service plans, reduces barriers to access, and reduces duplication of effort between case management programs. Coordination includes advocating for clients who have been denied services for which they are eligible.

- **Monitoring and re-assessment** is an ongoing process in which case managers continually evaluate and follow up with clients to assess their progress and to determine the need for changes to service and treatment plans.

- **Discharge** involves transitioning clients out of case management services because they no longer need them, have moved, or have died. For clients that move to other service areas, case managers should work to establish the appropriate referrals.

2.4 Chronic Disease Management

Chronic disease management is an approach to health care that involves supporting individuals to maintain their independence and to stay as healthy as possible. It relies on early diagnosis and effective management of chronic conditions to prevent progression, reduce risk of complications, prevent associated illnesses, and enable people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes, and access appropriate support are all factors that influence successful management of an ongoing illness.

PLWH need support and information to become effective managers of their own health. Chronic conditions require not just medical interventions, but behavioral interventions as well. Clients with chronic conditions such as HIV, play a large role in managing their conditions. Each client is at a different place in the process and appropriate interventions are driven, to a large extent, by each client's desired outcomes. To meet these needs, it is essential for clients to have the following:

- Basic information about HIV and its treatment
- Understanding of and assistance with self-management skill building
- Ongoing support from members of the health care and case management team, family, friends, and community.

Improving the health of people with chronic illnesses requires transforming a health care system that is now essentially reactive – responding when a person is sick and/or in crisis – to one that is proactive and focused on keeping a person as healthy as possible. This requires not only determining what care is needed, but also spelling out roles and tasks in a structured, planned way. This helps to ensure that everyone involved as a part of the client's care team understands their role. It also requires making coordinated follow-up a part of the standard procedure, so that clients are not left on their own once they leave the doctor or case manager's office. Clients with complex needs require more intensive case management for a period of time to optimize their clinical care, the effectiveness of their treatment regimen, and their self-management behavioral skills.

Effective self-management support does not mean telling clients what to do. It means acknowledging the client's central role in their own care and fostering the client's sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. But self-management can't begin and end with a class. Using a collaborative approach, case managers and clients work together to define problems, set priorities, establish goals, create care plans, and solve problems along the way.

Below are the key components of chronic disease management & client self-management:

- An emphasis on the client's role
- A standardized assessment
- Effective, evidence-based interventions
- Care planning (goal-setting) and problem solving
- Active, sustained follow-up.

2.5 Client-Centered Approach to Case Management

The client-centered model was originally developed by Carol Rogers and contains these key elements of a helping relationship: empathy, respect, and genuineness. The fundamental principle of the approach is that all people have an inherent tendency to strive toward growth, self-actualization, and self-direction. A client-centered approach places the needs, values, and priorities of the client as the central core around which all interaction and activity revolve. Understanding how the clients perceive their needs, their resources, and their priorities for utilizing services to meet their needs is essential if the case management relationship is truly going to be client-centered.

Each client has the right to personal choice, although these choices may conflict with reason, practicality or the case manager's professional judgment. The issue of valuing a client's right to personal choice is a relatively simple matter when the case manager and client's priorities are compatible. It is when there is a difference between the priorities of the case manager and the client that the case manager must make a diligent effort to distinguish between her or his own values and judgments and those of the client. One of the most difficult challenges for a case manager is to see their client making a choice that will probably result in negative outcomes, and which opposes the case manager's best counsel. In these situations, case managers must be willing to let the client experience the consequences of their choices, and hope that the relationship with the case manager will be a place to which the client can return for support without being judged. The important exception is when the client is planning to harm themselves or others.

It is the case manager's responsibility to:

- Offer accurate information to the client
- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions
- Present options to the clients from which they may select a course of action or inaction
- Offer direction when it is asked for, or when withholding it would place the client or someone else at risk for harm.

3.0 Case Management Standards of Care

Standards provide a direction to the delivery of case management services. They provide a framework for evaluating services, and they define the professional case manager's accountability to the public and the client. Standards of care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by IDPH.

This section provides the standards of care for the Ryan White Case Management services that are currently provided in Iowa.

3.1 Iowa's Case Management Model

Case Management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for PLWH.

The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and it supports a client's right to privacy, confidentiality, self-determination, dignity, and respect. Case management should include compassionate, non-judgmental care from a culturally competent provider.

Recognizing changes occurring in the HIV epidemic and in the needs of persons living with HIV, the Iowa Department of Public Health (IDPH) currently offers four tiers or levels of case management services: **Medical Case Management (MCM), Non-Medical Case Management (Non-MCM), Brief Contact Management (BCM), and Maintenance Outreach Support Services (MOSS).**

These four tiers of case management may be provided in health care or social service settings, in large institutions, or in small community-based organizations.

Medical Case Management (MCM) is a proactive case management model intended to serve PLWH with multiple complex medical and/or adherence-related issues. This level is designed to serve individuals who may require assistance with access, utilization, retention, and adherence to medications or health care services. MCM clients need ongoing support to actively engage in medical care and to remain adherent to treatment.

Non-Medical Case Management (Non-MCM) is a proactive case management model intended to serve PLWH with complex psychosocial needs. This level is designed to serve individuals who may require a longer time investment to stabilize their psychosocial needs. Non-MCM is also an appropriate service for clients who have completed medical case management, but still require a maintenance level of periodic support from a case manager or case management team. Non-MCM clients manage their care well enough to avoid chronic disruption to their medical care, but they still require psychosocial support to maintain a stable lifestyle.

Brief Contact Management (BCM) is an empowerment case management model intended to support PLWH independence in decision-making and in accessing services for their health-related and/or

psychosocial needs. This level is designed to assist individuals whose needs are minimal and infrequent. The BCM level is suitable for persons that exhibit a high level of understanding and acceptance of HIV. BCM clients have the life skills and personal resources to self-manage their care with only occasional assistance from a case manager.

Maintenance Outreach Support Service (MOSS) is designed for PLWH who were formerly engaged in more intensive levels of case management and have progressed to self-management. MOSS is intended to assess the sufficiency of self-management and to provide additional services, when appropriate, to prevent lapses in care. MOSS clients often experience life problems (e.g., co-morbidities, insufficient income, social isolation, and problematic relationships), but have the skills and personal resources to deal with them without regular assistance from a case manager.

3.2 Core Elements

The Core Elements table outlines the core requirements of each level of case management. For a quick reference, print this chart. The details of each element are described in the standards.

CORE ELEMENTS	**Medical Case Management (MCM)**	**Non-Medical Case Management (Non-MCM)**	**Brief Contact Management (BCM)**	**Maintenance Outreach Support Services (MOSS)**
Approach	***Proactive***	***Proactive***	***Responsive***	***Responsive***
ADAP	All clients enrolled in ADAP must be enrolled in MCM, Non-MCM, or BCM			N/A
Bill to/ Service Category	Medical Case Management	Non-medical Case Management	Psychosocial Support Services	Outreach Services
Brief Intake	**Required – new clients only**	**Required – new clients only**	**N/A** All clients are required to have a 3-month minimum period of more intensive service (either Medical or Non-medical Case Management) to ensure needs have been met prior to being transferred to Brief Contact Management	**N/A** All clients are required to have a 3-month minimum period of more intensive service (either Medical or Non-medical Case Management) to ensure needs have been met prior to being transferred to Maintenance Outreach
Assessment	**Iowa Standard Assessment required annually** **Reassessed at least every 6 months (6-month assessment using Iowa Acuity Scale)** Face to face	**Iowa Standard Assessment required annually** **Reassessed at least every 6 months (6 month assessment using Iowa Acuity Scale)** May be face to face or via phone. Initial assessment must be face to face	**Reassessed at least annually (using Iowa Acuity Scale)** May be face to face or via phone	**Not required** **Annual check-in required (see standards for Check-in components)** May be face to face or via phone

Care Plan	**Required** The care plan is updated when: - Unanticipated changes take place in life - When a change in the plan is identified - When progress occurs - Or at least every 6 months when reassessment occurs	**Required** The care plan is updated when: - Unanticipated changes take place in life - When a change in the plan is identified - When progress occurs - Or at least every 6 months	**Not Required** Development of a Care Plan is optional	**Not Required** Referral back into Medical Case Management, Non-Medical Case Management, or Brief Contact Management if client shows a need for more intense level of service
Referral	The case manager will document all referrals The case manager will document follow-up activities and outcomes The case manager will utilize a Care Plan or other tracking mechanism to monitor completion of all case management referrals	The case manager will document all referrals The case manager will document follow-up activities and outcomes The case manager will utilize a Care Plan or other tracking mechanism to monitor completion of all case management referrals	The case manager will document all referrals	Referral back into Medical or Non-Medical Case Management if client shows a need for a more intense level of service The case manager will document all referrals
Access to and Coordination with medical care	Coordination and follow up of medical treatment Case manager will maintain regular communication with client's HIV care provider (case consultation will take place, at a minimum, every 6 months) Case manager will assist with scheduling	Client reports an ability to self-manage care. Assistance is provided upon request	Not Required	Not Required

	appointments, following up on missed appointments and adherence planning			
Transition between Tiers	Movement can take place at any time after assessment shows stability	Movement can take place at any time, after assessment shows stability or a need for more intense level of services	Movement can take place at any time, after assessment shows stability or a need for more intense level of services Client must receive Medical or Non-Medical Case Management for a minimum of 3 months before transition to BCM	Movement can take place at any time, after check-ins show stability or a need for more intense level of services Client must receive Medical or Non-Medical Case Management for a minimum of 3 months before transition to MOSS
Service Units	A "service unit" is documented in 15 minute increments, entered as "Medical Case Management"	A "service unit" is documented in 15-minute increments, entered as "Non-Medical Case Management"	A "service unit" is documented in 15 minute increments, entered as "Psychosocial Support Services"	A "service unit" is documented in 15-minute increments, entered as "Outreach Services"
Client Contact	Case manager will have client contact a minimum of 1 time per month	Case manager will have client contact a minimum of 1 time every 3 months	Case manager will have client contact a minimum of 1 time every 6 months	Case manager will have client contact a minimum of 1 time annually
Eligibility Determination	Eligibility documentation is reviewed every 6 months	Eligibility documentation is reviewed every 6 months	Eligibility is assessed every 6 months via client self-attestation	Eligibility documentation is reviewed annually or as additional services are requested

3.3 Format of Standards

Each of the standards will be presented in the format described below. Review the table and refer back to this section if you have any questions while reading the following sections.

Service Category – Each service category will have a brief description of the service category.

CAREWare Service units – Each service category will have a "service unit" defined for measurement purposes.

Key Activities – Each service category will have a bulleted list of key activities to be performed as part of the service.

The standard will then be broken down by "key activities" performed, and outlined in the table, including the Standard, Criteria, and Documentation. See the table below for more information.

Key Activity
Purpose: Provides the purpose of the key activity

Standard	Criteria	Documentation
Minimum requirement that programs are expected to meet when providing services.	Specific activities required to meet the standard.	Documentation required.

3.4 Medical Case Management

Medical Case Management Services (MCM) is a proactive case management level intended to serve PLWH with multiple complex medical and/or adherence health-related needs. MCM is designed to serve individuals who may require assistance with access, utilization, retention, and adherence to health care services. MCM clients need ongoing support to actively engage in medical care, and continued adherence to treatment.

MCM services are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatment is an important component of MCM. This level of service ensures timely and coordinated access to medically appropriate levels of health and support services. It also focuses on ensuring continuity of care through ongoing assessment of the client's needs. MCM services must be culturally and linguistically appropriate to the populations served. MCM may be delivered face to face, via telephone, or using other forms of communication appropriate for the client. A primary goal of MCM is to help clients address barriers directly affecting their abilities to adhere to medical advice. MCM's hallmark characteristic is having the case manager work directly with the client's HIV medical providers to address these issues.

Service units of MCM services are documented in 15-minute increments as "medical case management" in CAREWare.

Key Activities

- Eligibility determination
- Brief intake (new clients only)
- Assessment and reassessment
- Care Plan development
- Implementing and monitoring the Care Plan
- Consulting with medical providers
- Adherence planning
- Making active referrals and following up
- Transition and case closure
- Records management
- Case load management

At a minimum, MCM must include the following:

- Provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV treatments
- Consultation and follow-up of medical treatments with HIV medical provider
- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients to access long-term support for health care costs, including Medicaid, Medicare, group or individual health insurance, and coverage under someone else's health insurance policy.

Medical case managers must maintain proficiency in the following care-related services:

- ADAP
- Medicaid and Medicare
- Iowa's Insurance Marketplace and open market insurance options
- HOPWA

Eligibility Determination

Purpose: Eligibility determination is the process for collecting the required documents from the client to determine eligibility for Ryan White services based on the eligibility criteria for each service. All services require the following documents: proof of address, proof of income, and proof of HIV-positive status.

Standard	Criteria	Documentation
Documentation for client eligibility will be collected.	Eligibility criteria for MCM includes: - HIV-positive status - Iowa residency - Income at or below 400% FPL	Part B provider has documentation on file that client meets eligibility criteria. Documentation that client meets eligibility criteria is

	Eligibility must be re-evaluated every six months for every active client.	collected and present in client file. At the 6 month re-evaluation, a client self-attestation is acceptable proof.

Brief Intake

Purpose: The brief intake is the process for collecting information during the first contact with new incoming clients to determine service needs.

Standard	Criteria	Documentation
Brief intake will be completed with all new incoming clients.	Brief intake (page 2 of the Iowa Part B application) is completed during first contact with new incoming clients. First contact can take place over the phone or in person.	Part B provider documentation in client file of completed brief intake for new clients.

Assessment and Reassessment

Purpose: The focus of the assessment is to evaluate the client's medical and psychosocial needs, strengths, resources, limitations, and projected barriers to utilizing services. Barriers identified from the assessment are used to develop the care plan and to inform the coordination of a continuum of care that provides:

- Timely access to medically-appropriate levels of health and support services
- An ongoing assessment of the client's and other family members' needs and personal support systems
- A coordinated effort with other agencies

Standard	Criteria	Documentation
Working collaboratively with the client, the case manager conducts a confidential, comprehensive, face-to-face Iowa Standard Assessment to assess the need for medical, dental, psychosocial, educational, financial, nutritional, mental health, substance use, risk reduction, and other services.	The case manager conducts an Iowa Standard Assessment. The assessment should be completed at the earliest convenience of the client, but no later than 30 days after completion of the "Brief Intake." The case manager should use the "Acuity Scale" as a measurement tool to determine client needs. The acuity scale indicates:	An Iowa Standard Assessment is completed and present in client file. An Iowa Acuity Scale is completed and present in client file.

	- The level of case management - The frequency of contact	
MCM should be responsive to the current situation of the client and reassessments should be conducted regularly.	As a client's status changes, it will be necessary for the case manager to reassess his or her needs and acuity level. The case manager should use the Iowa Acuity Scale as a tool to determine client needs. The Iowa Acuity Scale indicates: - The level of case management complexity Reassessment of the client's needs is conducted as needed, but not less than once every six months. The Iowa Acuity Scale is used as 6-month reassessment document along with a narrative case note detailing the assessment. The Iowa Standard Assessment* is used as the annual reassessment document.	An Iowa Standard Assessment* is completed and present in client file. An Iowa Acuity Scale is completed and present in client file. A case note is completed and present in client file.

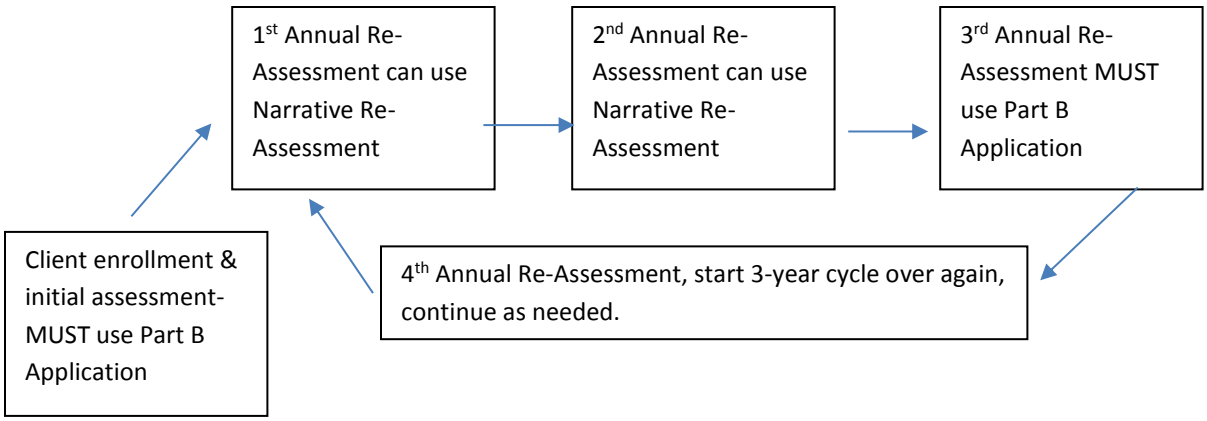
Narrative Reassessment

Purpose: The focus of the Narrative Reassessment is to evaluate the client's medical and psychosocial needs, strengths, resources, limitations, and projected barriers to utilizing services. Barriers identified from the assessment are used to develop the care plan and to inform the coordination of a continuum of care that provides:

- Timely access to medically-appropriate levels of health and support services
- An ongoing assessment of the client's and other family members' needs and personal support systems
- A coordinated effort with other agencies

IDPH must approve use of the Narrative Reassessment for each individual case manager. The Narrative Re-assessment can take the place of the Ryan White Part B Application twice in a three year cycle. The cycle is depicted below:

* A Narrative Assessment is available for use with approval from IDPH.



To request approval to use the Narrative Re-Assessment, please contact the Client Services Coordinator.

Care Plan Development

Purpose: The care plan is a critical tool to identify and address barriers impeding the client's ability to obtain services independently. Together, the client and case manager identify problems or issues to address or change, barriers to care, and strategies for overcoming those barriers. The Care Plan aids the case manager in assessing appropriate referrals to help the client achieve a desired outcome, and enhance the client's health status and quality of life.

Standard	Criteria	Documentation
The client's individualized Care Plan is a strengths-based case management work plan, which systematically identifies client needs based on a comprehensive client assessment. The Care Plan worksheet shall be completed and utilized by the case manager and the client.	The Care Plan is a strategy, tool, or plan of action designed cooperatively by the case manager and client as a means to help the client achieve goals. Goals, objectives, and action steps are identified and prioritized. Care Plans include: - Overarching goals - More specific Objectives encompassed within a goal - Specific action steps to address each Objective - A timeline - A plan for follow up	An individualized Care Plan based on need identified is complete and present in client file. Care Plan indicates: - Goals - Objectives - Action Plan - Changes or updates At least one goal in the Care Plan should address adherence to treatment and/or medical care.
The case manager and client will work together to decide a timeline and who will take responsibility for each task.	A reasonable timeline is determined for achievement of goals, with tasks assigned to either case manager or client. The majority of tasks should be assigned to the client.	The Care Plan indicates the individual responsible for each task. The Care Plan indicates anticipated time frame for each task.

Reassessment of Care Plan goals is completed as needed, but no less than once every six months. A new Care Plan is developed as needed, but no less than annually.	The Care Plan is updated when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals, or at least every six months when reassessment occurs.	Updates are made to the Care Plan upon achievement of goals, when other issues or goals are identified, or at least every six months, when reassessment occurs. A new Care Plan is completed and present in client file at least annually.

Implementing and Monitoring the Care Plan

Purpose: Implementation of the client's goals, objectives, and action steps is the crux of case management. It is a critical component of MCM to monitor the progress of the care plan to ensure best health outcomes. Monitoring is an ongoing data collection process that documents successes or continued barriers. The frequency of monitoring depends on the level and intensity of client need.

Standard	Criteria	Documentation
Clients should receive MCM that is suited to their situation.	The Care Plan should be consistent with the needs identified in the Iowa Standard Assessment.	Care Plan consists of goals, objectives, and action steps relevant to client needs.
MCM should be relevant to the client's current situation.	The strategy or plan of action should be consistent with the updated Care Plan including: - Assistance in arranging services, making appointments, and confirming service delivery dates - Encouragement for client to carry out tasks they agreed to - Support to enable clients to overcome barriers and access services - Negotiation and advocacy as needed - Other case management activities as needed.	Progress notes by the case manager detailing the action taken should be documented and dated on the Care Plan and in Case Notes. This should include ongoing documentation of the following: - Progress made towards Care Plan goals - Action taken to overcome barriers - Completion/revision of Care Plan goals.
Case Manager will provide active referrals, advocacy, and interventions based on the Care Plan	Monitoring involves carrying out tasks listed in the Care Plan, including the following activities: - Contact with client in person, by phone, or in writing - Conducting ongoing monitoring and follow up with clients and providers to confirm	The client file indicates ongoing documentation found in the Care Plan and in Case Notes of the following: - Specific data about all encounters with the client, including date of encounter, type of encounter, duration of

	completion of referrals, service acquisition, maintenance of services, and adherence to medical care - Actively following up on established goals in the Care Plan to evaluate client progress and determine appropriateness of services - Assisting clients in resolving any barriers to completing goals in Care Plan.	encounter, and services provided - All MCM contacts with the client's support system, providers, and other relevant individuals - Progress made toward Care Plan - Barriers identified and actions taken to resolve them - Results of referrals
Determination of the need for Care Plan revision.	Case manager will revise Care Plan as changes in client circumstances warrant, at a minimum once every six months.	The case manager will document all updates in the Care Plan.
Case Manager will maintain ongoing client contact	There should, be at a minimum, one face-to-face contact per client every six months and one telephone contact per month. Home visits should be conducted, as needed. Case managers shall actively follow up with clients who have missed case management appointments. Follow up may include: - Telephone calls - Written correspondence - Face-to-face contact	Document all client contact, attempts to contact, and any action taken to locate client in Case Notes and in Care Plan, as appropriate.

Consultation with Medical Provider

Purpose: Direct consultation with the clients HIV medical provider is the hallmark of MCM. Without this component, MCM is not occurring. This activity is critical to ensure the highest likelihood for the best health outcomes for the newly diagnosed and those with complex needs.

Standard	Criteria	Documentation
Medical case managers shall maintain communication with client's HIV care provider.	Medical case managers will make contact with a client's HIV care clinic at a minimum of twice a year, or as clinically indicated.	Client file must include: - HIV care provider name/clinic - Documentation of contact with HIV medical clinics and providers in Case Notes - Medical history - All current medications

	HIV care provider is defined as treating physician, a nurse of the treating physician, or another qualified staff member.	- Date of last clinic visit - Results of last CD4+ and viral load (uploaded automatically by IDPH). It is required that these clinic data be reported directly from the medical provider and/or IDPH and not from the client.
Clients who are not engaged in care should be referred to a HIV care physician.	If a client is not seeing a HIV care physician regularly, he or she should be urged to seek care, and a referral to an appropriate HIV care physician should be made.	Referral documented in Case Notes and Care Plan, as needed.
Case reviewing utilized as a specific mechanism to enhance case coordination.	Interdisciplinary case review should be held for each client at least every 6 months, or more often if clinically necessary. Case review must include, at a minimum, HIV care provider, case manager, and any other medical or service provider deemed necessary.	Evidence of timely case reviewing with key providers is found in Case Notes. Case reviews may take place face to face, by phone, or electronically.
Determination of the need for Care Plan revision.	Case manager will revise Care Plan as changes in client circumstances warrant, at a minimum once every six months.	The case manager will document all updates to Care Plan.

Active Referral and Follow-up

Purpose: Often times, to most effectively address the barriers that clients face, a referral to another agency or program must be made. Referrals should be appropriate to the client's situation, lifestyle, and need. After a referral is made, the case manager should follow up to ensure that services are being received. Agency eligibility requirements should be considered part of the referral process. Follow up is a systematic process to determine if the client is accessing services. The case manager will ensure clients are accessing referrals and services, and will identify and resolve any barriers clients may have in following through with the referral.

Standard	Criteria	Documentation
Each client will receive active referrals to those services critical to achieving optimal health and well-being.	The case manager will support the client to initiate referrals that were agreed upon by the client and the case manager. Active referrals include: - Referral to a named agency	All of the elements of an active referral should be documented in the client Case Notes and Care Plan, as needed.

	- The name of a contact person at the referral agency - An exact address - Specific instructions on how to make the appointment - Identifying referral agency eligibility requirements - What to bring to the appointment.	
As appropriate, the case manager shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the referral agency.	Signed release of information forms are obtained, as necessary.	Signed release of information form present in client file.
Each client will receive assistance to help problem solve when barriers impede access.	The case manager will work with the client to identify barriers to referrals and assist in finding solutions to address barriers.	The case manager will document all barriers identified in referral process and actions taken to resolve them in Case Notes and Care Plan, as needed.
The case manager will ensure clients are accessing referrals.	The case manager will utilize Care Plan as a tracking mechanism to monitor completion of all active referrals relevant to Care Plan goals. The case manager will utilize a tracking mechanism to monitor completion of all other active referrals.	Case manager will document follow-up activities and outcomes in Case Notes, on Care Plan, as needed, and/or other tracking mechanism.

Transition and Client Discharge

Purpose: Case transition is a systematic process for transitioning clients from MCM services. To assist the clients in moving toward empowerment, self-determination, and self-sufficiency, the medical case manager will transfer the client to a less intensive case management service as the client demonstrates the ability to independently manage her or his care. The process includes formally notifying clients of pending case transition and completing the Iowa Acuity Scale, which is to be kept in the client's file. Client Discharge is a systematic process for discharging a client from case management services because of self-sufficiency, voluntary request, relocation outside of Iowa, death, etc.

Standard	Criteria	Documentation
At the conclusion of MCM services, the client's goals should have been met, a	Clients being transitioned should demonstrate one or	Transitioning clients files will include:

completed Iowa Acuity Scale recommends a lower level of case management and, when appropriate, there should be a seamless transition to less intensive case management services (such as Non-medical Case Management, Brief Contact Services, or Maintenance Outreach Services Support), or referral to Data to Care Program, or Client Discharge.	more of the MCM case transition criteria: - Successful completion of all goals in the Care Plan - Completed Iowa Acuity Scale recommending less intense case management services Clients being discharged should demonstrate one or more of the MCM client discharge criteria: - Voluntary withdrawal from the service - Death of the client - Relocation outside the service area - Client otherwise lost to service (unable to locate after 3 months of attempts – MCM will complete the Diligent Search Care Plan/Assessment, and if appropriate refer the client to the Data to Care Program) - Client demonstrates the ability to independently manage their care in a sustainable manner and does not show a need for other case management services - Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the staff or unlikely to be helpful to the client.	- Documentation of completed goals in the Care Plan - Completed Iowa Acuity Scale. Clients referred to Data to Care Program files will include: - Completed Diligent Search Care Plan/Assessment. - Completed Data to Care Referral form. Discharged clients' files will include: - Completed Ryan White Part B Case Management Discharge Summary. A copy of the completed Ryan White Part B Case Management Discharge Summary will be faxed to the IDPH.

3.5 Non-Medical Case Management

Non-Medical Case Management (Non-MCM) is a proactive case management level intended to serve PLWH with multiple complex psychosocial needs. The level is designed to serve individuals who may require a longer time investment to stabilize their psychosocial needs. Non-MCM is also an appropriate service for clients who have completed MCM, but still require a maintenance level of periodic support from a case manager or case management team. Non-MCM clients manage their care well enough to

avoid chronic disruption to their medical care but require psychosocial support to maintain a stable lifestyle.

Non-MCM may also be provided to clients with complex needs who may best be served by MCM, but who are not ready or willing at this time to engage in the level of participation required by the MCM model. In this case, Non-MCM serves as a means of assisting an individual at his/her level of readiness, while encouraging the client to consider more comprehensive services.

Non-MCM includes the provision of referrals and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-MCM does **not** involve coordination and follow up of medical treatments, as MCM does.

CAREWare "Service units" of non-medical case management are documented in 15-minute increments as "Non-Medical Case Management" in CAREWare.

Key Activities

- Eligibility determination
- Conducting a brief intake
- Assessment and reassessment of service needs
- Development of a brief, individualized Care Plan
- Implementing and monitoring the Care Plan
- Making referrals and following up
- Client transition and discharge

At a minimum, Non-MCM must including the following:

- Client-specific advocacy and/or review of utilization of services
- Motivating and assisting clients with access to long-term support for health care costs, including Medicaid, Medicare, group or individual health insurance, and/or coverage under someone else's health insurance policy.

Case Managers must also maintain proficiency regarding the following care-related services:

- ADAP
- Iowa's Insurance Marketplace
- Medicaid and Medicare
- HOPWA

Eligibility Determination

Purpose: Eligibility determination is the process for collecting the required documents from the client to determine eligibility for Ryan White services based on the eligibility criteria for each service. All services require the following documents: proof of address, proof of income, and proof of HIV-positive status.

Standard	Criteria	Documentation	
Documentation for client eligibility will be collected.	Eligibility criteria for Non-MCM includes: - HIV-positive status - Iowa residency - Income at or below 400% FPL Eligibility must be re-evaluated every six months for every active client.	Part B provider has on file documentation that client meets eligibility criteria. Documentation that client meets eligibility criteria is collected and present in client file. At the 6 month re-evaluation, a client self-attestation is acceptable proof.	

Brief Intake

Purpose: The brief intake is the process for collecting information during the first contact with new incoming clients to determine need for services.

Standard	Criteria	Documentation
Brief intake will be completed with all new incoming clients.	Brief intake (page 2 of the Iowa Part B application) is completed during first contact with new incoming clients. First contact can take place over the phone or in-person.	Part B provider documentation in client file of completed brief intake for new clients.

Assessment and Reassessment

Purpose: The focus of the assessment is to evaluate the client's medical and psychosocial needs, strengths, resources, and projected barriers to utilizing services. Barriers identified from the assessment are used to develop the care plan.

Standard	Criteria	Documentation
Working collaboratively with the client, the case manager conducts a confidential, comprehensive, face-to-face Iowa Standard Assessment* to assess the need for medical, dental, psychosocial, educational, financial,	The case manager conducts an Iowa Standard Assessment* with the client following the intake. The assessment should be completed at the earliest convenience of the client, but no later than 30 days after completion of the Brief Intake.	The Iowa Standard Assessment* is completed and present in client file. The Iowa Acuity Scale is completed and present in client file.

* A Narrative Assessment is available for use with approval from IDPH.

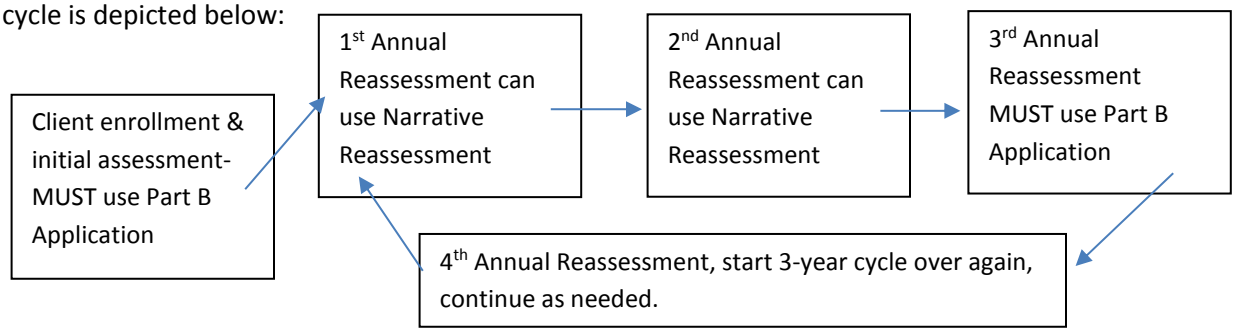
nutritional, mental health, substance use, risk reduction, and other services.	The case manager should use the Iowa Acuity Scale as a measurement tool to determine client needs. The acuity scale indicates: - The level of case management - The frequency of contact	
Non-MCM should be responsive to the current situation of the client and reassessments should be conducted regularly.	As a client's status changes, it will be necessary for the case manager to reassess their needs and acuity level. The case manager should use the Iowa Acuity Scale as a tool to determine client needs. The Iowa Acuity Scale indicates: - The level of case management complexity. - The complexity of the caseload Reassessment of the client's needs is conducted as needed, but not less than once every six months. The Iowa Acuity Scale is used as 6-month reassessment document along with a narrative case note detailing the assessment. The Iowa Standard Assessment is used as the annual reassessment document along with a case note detailing the assessment.	The Iowa Standard Assessment is complete and present in the client file at least annually. The Iowa Acuity Scale is complete and present in the client file at least annually. A case note is completed and present in client file.

<u>Narrative Reassessment</u>

Purpose: The focus of the Narrative Reassessment is to evaluate the client's medical and psychosocial needs, strengths, resources, limitations, and projected barriers to utilizing services. Barriers identified from the assessment are used to develop the care plan and to inform the coordination of a continuum of care that provides:

- Timely access to medically-appropriate levels of health and support services
- An ongoing assessment of the client's and other family members' needs and personal support systems
- A coordinated effort with other agencies

IDPH must approve use of the Narrative Reassessment for each individual case manager. The Narrative Re-assessment can take the place of the Ryan White Part B Application twice in a three year cycle. The cycle is depicted below:



To request approval to use the Narrative Reassessment, please contact the Client Services Coordinator.

Care Plan Development

Purpose: The care plan is a critical tool to identify and address barriers impeding the client's ability to obtain services independently. Together, the client and case manager identify problems or issues to address or change, barriers to care, and strategies for overcoming those barriers. The Care Plan aids the case manager in assessing appropriate referrals to help the client achieve a desired outcome and enhance the client's health status and quality of life.

Standard	Criteria	Documentation
The client's individualized Care Plan is a strengths-based case management work plan, which systematically identifies client needs based on the Iowa Standard Assessment. The Care Plan Worksheet shall be completed and utilized by the case manager and the client.	The Care Plan is a strategy, tool, or plan of action designed by both case manager and client as a means to help the client achieve goals. Goals, objectives, and action steps are identified and prioritized. Care Plans include: - Overarching goals - More specific objectives encompassed within a goal - Specific action steps to address each objective - A timeline - A plan for follow up.	An individualized Care Plan based on needs identified is signed, dated, and present in client's file. Care Plan consists of goals, objectives, and action steps relevant to client needs. The Care Plan is updated when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals, when reassessment occurs, or at least every six months.
The case manager and client will work together to decide a timeline and who will take responsibility for each task.	A reasonable timeline is determined for achievement of goals, with tasks assigned to either client or case manager. The majority of tasks should be assigned to the client.	The Care Plan indicates the individual responsible for each task. The Care Plan indicates anticipated time frame for each task.

Reassessment of Care Plan goals is completed as needed, but not less than once every six months. A new Care Plan is developed as needed, but not less than annually.	The Care Plan is updated when unanticipated changes take place in the client's life, when a change in the plan is identified, upon achievement of goals, when reassessment occurs, or at least every six months. A new Care Plan is developed as needed, but no less than annually.	Updates are documented at least every six months. A new Care Plan is completed at least annually and present in the client's file.

Implementing and Monitoring the Care Plan

Purpose: Implementation of the client's goals, objectives, and action steps is the crux of case management. It is a critical component of Non-MCM to monitor the progress of the care plan to ensure best health outcomes. Monitoring is an ongoing data collection process that documents successes or continued barriers. The frequency of monitoring is depended on the level and intensity of client need.

Standard	Criteria	Documentation
Clients should receive Non-MCM that is suited to their situation.	The Care Plan should be consistent with the need identified in the Iowa Standard Assessment.	Care Plan consists of goals, objectives, and action steps relevant to client needs.
Non-medical case management should be relevant to the client's current situation.	The strategy or plan of action should be consistent with the updated Care Plan including: - Refer client to needed services - Encourage client to carry out tasks they agreed to - Support to enable clients to overcome barriers and access services - Negotiate and advocate, as needed - Other case management activities, as needed	Progress notes by the case manager detailing the action taken should be documented and dated on the Care Plan and in Case Notes. This should include ongoing documentation of the following: - Progress made towards Care Plan goals - Action taken to overcome barriers
Non-medical case manager will provide active referrals, advocacy, and interventions based on the Care Plan	Monitoring involves carrying out tasks listed in the Care Plan, including the following activities: - Contact with client in person, by phone, or in writing - Conducting ongoing monitoring and follow up with clients to confirm completion of	The client file indicates ongoing documentation found in the Case Notes and Care Plan as needed of the following: - Specific data about all encounters with the client, including date of encounter, type of encounter, duration of

	referrals, service acquisition, maintenance of services, and adherence to medical care - Actively following up on established goals in the Care Plan to evaluate client progress and determine appropriateness of services - Assisting clients in resolving any barriers to completing goals in Care Plan.	encounter, and services provided - All Non-MCM contacts with the client's support system, providers, and other relevant individuals - Progress made toward Care Plan - Barriers identified and actions taken to resolve them - Current status and results of referrals
Determination of the need for Care Plan revision.	Case manager will revise Care Plan as changes in client circumstances warrant, at a minimum once every six months.	The case manager will document all updates in the Care Plan.
Case managers will maintain ongoing client contact	There should be, at a minimum, one face-to-face contact per client annually and one telephone contact every six months. Home visits should be conducted, as needed. Case managers shall actively follow up with clients who have missed case management appointments. Follow up may include: - Telephone calls - Written correspondence - Face-to-face contact	Document all client contact, attempts to contact and any action taken to locate client in Case Notes and in Care Plan, as appropriate.

Referral and Follow-up

Purpose: Often, to most effectively address the barriers that clients face, a referral to another agency or program must be made. Referrals should be appropriate to the client's situation. After a referral is made, the case manager should follow up to ensure that services are being received. Agency eligibility requirements should be considered part of the referral process. Follow up is a systematic process to determine if the client is accessing services. The case manager will ensure clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with the referrals.

Standard	Criteria	Documentation
Each client will receive referrals to those services critical to achieving optimal health and well-being.	The case manager will support the client to initiate referrals that were agreed upon by the client and the case manager. Referrals include:	All of the elements of a referral should be documented in the client Care Plan and/or Case Notes.

	- Referral to a named agency; - The name of a contact person at the referral agency; - An exact address; - Specific instructions on how to make the appointment; - Identifying referral agency eligibility requirements; and - What to bring to the appointment.	
Each client will receive assistance to help problem solve when barriers impede access.	The case manager will work with the client to identify barriers to referrals and assist in finding solutions to address barriers.	The case manager will document all barriers identified in the referral process and actions taken to resolve them in the client Care Plan and/or Case Notes.
The case manager will ensure clients are accessing needed referrals.	The case manager will use the Care Plan as a tracking mechanism to monitor completion of all referrals relevant to Care Plan goals. The case manager will utilize a tracking mechanism to monitor completion of all other active referrals.	Case manager will document follow-up activities and outcomes in Case Notes, on Care Plan, and/or other tracking mechanism.

Transition and Client Discharge

Purpose: Case transition is a systematic process for transitioning clients from Non-MCM services. To assist the clients in moving toward empowerment, self-determination, and self-sufficiency, the case manager will transfer the client to a less intensive case management service as the client demonstrates the ability to independently manage her or his care. The process includes formally notifying clients of pending case transition and completing the Iowa Acuity Scale, which is to be kept in the client's file. Case transition also takes place when a client presents the need for more intense case management services. Client Discharge is a systematic process for discharging a client from case management services because of self-sufficiency, voluntary request, relocation outside of Iowa, death, etc.

Standard	Criteria	Documentation
At the conclusion of Non-MCM services, the client's goals should have been met, a completed Iowa Acuity Scale recommends a lower level of case management and, when appropriate, there should be a seamless transition to less	Clients being transitioned should demonstrate one or more of the Non-MCM case transition criteria: - Successful completion of all goals in the Care Plan - Completed Iowa Acuity Scale recommending lesser or higher	Transitioning clients' files will include: - Documentation of completed goals in the Care Plan (not applicable if transitioning to higher level of case management) - Completed Iowa Acuity Scale

intensive case management services (such as Brief Contact Services or Maintenance Outreach Services Support) or The client demonstrated a need for more intense case management services and a completed Iowa Acuity Scale recommends a higher level of case management, or Referral to the Data to Care Program or Client Discharge	intensive case management services. Clients being discharged should demonstrate one or more of the Non-MCM client discharge criteria: - Voluntary withdrawal from the service - Death of the client - Relocation outside the service area - Client otherwise lost to service (unable to locate after 3 months of attempts – MCM will complete the Diligent Search Care Plan/Assessment, and if appropriate refer the client to the Data to Care Program) - Client demonstrates the ability to independently manage her or his care in a sustainable manner and does not show a need for other case management services - Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the staff or unlikely to be helpful to the client	Clients referred to Data to Care Program files will include: - Completed Diligent Search Care Plan/Assessment. - Completed Data to Care Referral form. Discharged clients' files will include: - Completed Ryan White Part B Case Management Discharge Summary A copy of the completed Ryan White Part B Case Management Discharge Summary is to be faxed to the IDPH.

3.6 Brief Contact Management

Brief Contact Management (BCM) is an empowerment case management model intended to assist PLWH to maintain independence in decision-making and in accessing services for their health-related and/or psychosocial needs. This model is designed to assist individuals whose needs are minimal and infrequent. BCM is suitable for persons that are doing very well and exhibit a high level of understanding and acceptance of HIV. This client exhibits the ability to navigate the care system independently and requires a lesser demand for more intensive case management. Other criteria include stability of disease process, independent functioning with no evidence of life-destabilizing issues, and compliance with a treatment regimen.

The BCM model gives the client the opportunity to graduate from more intensive tiers of case management into a self-management tier. Upon request, the client may receive advice and/or

assistance in obtaining medical, social, community, legal, financial, and other needed services. BCM does not involve coordination and follow up on medical treatments. BCM also does not require the development and monitoring of a Care Plan.

Clients should not be admitted directly to BCM services. All clients should have an opportunity to have a period of more intensive service (either MCM or Non-MCM) to ensure needs have been met prior to being transferred to BCM. Clients must receive three months of a more intensive level of case management prior to transition to BCM.

CAREWare "Service units" of BCM are documented in 15-minute increments as "Psychosocial Support Services" in CAREWare.

Key Activities

- Eligibility determination
- Assessment and reassessment of service needs
- Making referrals and following up
- Client transition and discharge

Case Managers must maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- ADAP
- Iowa's Insurance Marketplace
- Medicaid and Medicare
- HOPWA

Eligibility Determination

Purpose: Eligibility determination is the process for collecting the documents required from the client to determine eligibility for Ryan White services based on the eligibility criteria for each service. All services require the follow eligibility determination documents: proof of address, proof of income, and proof of HIV-positive status.

Standard	Criteria	Documentation
Documentation for client eligibility will be collected.	Eligibility criteria for BCM includes: - HIV-positive status - Iowa residency - Income at or below 400% FPL Eligibility must be re-evaluated annually for every active client. 6-month eligibility criteria for BCM includes: - Client self-attestation	Part B provider has on file documentation that client meets eligibility criteria. Documentation that client meets eligibility criteria is collected and present in client file.

		Documentation of client self-attestation is documented in a case note.

Assessment and Reassessment

Purpose: The focus of the assessment is to evaluate the client's medical and psychosocial needs, strengths, resources, and projected barriers to using services. Barriers identified from the assessment are used to develop the Care Plan.

Standard	Criteria	Documentation
Working collaboratively with the client, the case manager conducts the Iowa Acuity Scale and narrative case note.	The case manager conducts an Iowa Acuity Scale and narrative case note with the client. The narrative case note includes a brief assessment of the following areas: - HIV medical care - HIV medication adherence - Other medical care/conditions - Income - Insurance - Housing - Mental Health - Transportation - Support system. The case manager should use the Iowa Acuity Scale as a measurement tool to determine client needs. The acuity scale indicates: - The level of case management	The Iowa Acuity Scale is completed and present in client file. The Case Note will be printed, present in client's file, and signed and dated by the case manager.
Case manager should be responsive to the current situation of the client and reassessments should be conducted regularly.	Reassessment of the client's needs using the Iowa Acuity Scale and completion of narrative case notes, as needed, but not less than annually.	The Iowa Acuity Scale and narrative case note is completed and present in client file at least annually.

Referral

Purpose: Referrals should be to secure care and services, not just to provide information. Referrals should be appropriate to the client situation.

Standard	Criteria	Documentation
The case manager will develop referral resources to make available the full range of additional services to meet the needs of their clients.	The case manager will develop and maintain comprehensive referral lists for a full range of services.	Comprehensive referral lists are developed and updated regularly.
Case managers will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	The case manager will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding or Memoranda of Agreement with service providers are on file, as necessary.
Each client receiving BCM services will receive referrals to those services critical to achieving optimal health and well-being.	The case manager will support the client to initiate referrals that were agreed upon by the client and the case manager.	The case manager will document when referrals are made and any follow-up in Case Notes.

Transition and Client Discharge

Purpose: Case transition is a systematic process for transitioning clients from BCM services. To assist the clients in moving toward empowerment, self-determination, and self-sufficiency, the case manager will transfer the client to a less intensive case management service as the client demonstrates the ability to independently manage her or his care. The process includes formally notifying clients of pending case transition and completing the Iowa Acuity Scale, which is to be kept in the client's file. Case transition also takes place when a client presents the need for more intense case management services. Client discharge is a systematic process for discharging a client from case management services because of self-sufficiency, voluntary request, relocation outside of Iowa, death, etc.

Standard	Criteria	Documentation
At the conclusion of BCM services, the client's needs should be met, a completed Iowa Acuity Scale recommends a lower level of case management and, when appropriate, there should be a seamless transition to less intensive case management services (Maintenance Outreach Support Services) or The client demonstrated a need for more intense case management services and a	Clients being transitioned should demonstrate one or more of the BCM case transition criteria: - Successful completion of meeting all needs identified - Completed Iowa Acuity Scale recommending lesser or higher intensive case management services Clients being discharged should demonstrate one or more of the BCM client discharge criteria: - Voluntary withdrawal from the service - Death of the client	Transitioning clients' files will include: - Documentation of needs identified being met (not applicable if transitioning to higher level of case management) - Completed Iowa Acuity Scale Clients referred to Data to Care Program files will include: - Completed Diligent Search Care Plan/Assessment. - Completed Data to Care Referral form.

completed Iowa Acuity Scale recommends a higher level of case management or Referral to the Data to Care Program or Client Discharge	- Relocation outside the service area - Client otherwise lost to service (unable to locate after 3 months of attempts – MCM will complete the Diligent Search Care Plan/Assessment, and if appropriate refer the client to the Data to Care Program) - Client demonstrates the ability to independently manage her or his care in a sustainable manner and does not show a need for other case management services - Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the staff or unlikely to be helpful to the client	Discharged clients' files will include: - Completed Ryan White Part B Case Management Discharge Summary A copy of the completed Ryan White Part B Case Management Discharge Summary will be faxed to the IDPH.

3.7 Maintenance Outreach Support Services

Maintenance Outreach Support Services (MOSS) is an empowerment case management model intended to assist PLWH who were formerly engaged in a more intensive level of case management and have progressed to self-management. This model is designed to assess the sufficiency of self-management and to provide additional services, when appropriate, to prevent lapses in care.

This model is designed as the maintenance step in the case management process in working to achieve and maintaining self-sufficiency. MOSS gives the client the opportunity to use skills and knowledge gained through case management to solve problems and address life's barriers on his or her own.

Clients should not be admitted directly to MOSS services. All clients should have an opportunity to have a period of more intensive service (MCM, Non-MCM, or BCM) to ensure needs have been met prior to being transferred to MOSS. Clients must receive three months of a more intensive level of case management prior to transition to MOSS.

MOSS is **not** a time-limited service and is designed as a mechanism to sustain regular contact with clients to ensure self-sufficiency is maintained indefinitely. If an individual requests additional services frequently, a more intense level of case management may be necessary. Clients enrolled in MOSS who show a higher level of need may be moved to a more intense level of case management at any time.

MOSS is a voluntary service, as are all levels of case management. If an individual does not wish to participate in MOSS, a discharge will occur.

"Service units" of MOSS are documented in 15-minute increments as "Service Outreach" in CAREWare.

Key Activities

- Annual check-in
- Making referrals and following up
- Transition and client discharge

Case managers must maintain proficiency regarding the following care-related services and must collaborate with the providers of such services:

- ADAP
- Iowa's Insurance Marketplace
- Medicaid (i.e., traditional State Plan)
- Medicare
- HOPWA

Annual check-in

Purpose: Once a client has been deemed appropriate for MOSS and agrees to participate, the case manager will conduct an annual check-in to ensure the client maintains self-sufficiency. Annual check-ins will take place for the duration of enrollment in MOSS.

Standard	Criteria	Documentation
Working collaboratively with the client, the case manager conducts a check-in with the client.	The case manager conducts a check-in annually. The annual check-in includes a brief assessment of the following areas: - HIV medical care - HIV medication adherence - Other medical care/conditions - Income (no FPL restrictions) - Insurance - Housing - Mental Health - Transportation - Support system - Eligibility determination. Annual check-ins can be conducted face to face or via phone.	The case manager will document the annual the check-in in a Case Note. Eligibility determination (proof of income and residency) will be documented as part of the annual check-in, client self-attestation is acceptable proof. This will be included in the Case Note. The Case Note will be printed, present in the client's file, and signed and dated by the case manager.

Referral

Purpose: Self-managed clients maintain the ability to access information and resources on their own. However, a referral may occasionally be necessary to secure care and services. Referrals should be appropriate to client situation.

Standard	Criteria	Documentation
The case manager will develop referral resources to make available the full range of additional services to meet the needs of their clients.	Case manager will develop and maintain comprehensive referral lists for a full range of services.	Comprehensive referral lists are developed and updated regularly.
Case managers will demonstrate active collaboration with other agencies to provide referrals to the full spectrum of HIV-related and other services.	Case manager will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding or Memoranda of Agreement with service providers are on file, as necessary.
Each client receiving MOSS services will receive referrals to those services critical to achieving optimal health and well-being.	The case manager will support the client to initiate referrals that were agreed upon by the client and the case manager.	The case manager will document when referrals are made and any follow-up in Case Notes.

Transition and Client Discharge

Purpose: Case transition is a systematic process for transitioning clients from MOSS. Case transition takes place when a client presents the need for more intense case management services. The process includes formally notifying clients of pending case transition and completing the Iowa Acuity Scale, which is to be kept in the client's file.

MOSS is designed to provide indefinite support to clients who have achieved self-sufficiency. A client should be maintained in MOSS unless the client requests to be discharged, is moved to a higher tier of case management, is incarcerated, moves out side of Iowa, or passes away. The process includes formally notifying clients of pending client discharge and completing the Iowa Ryan White Part B Case Management Discharge Form.

Standard	Criteria	Documentation
The client demonstrates a need for more intense case management services and a completed Iowa Acuity Scale recommends a higher level of case management. or	Clients being transitioned should demonstrate one or more of the MOSS case transition criteria: - Additional needs identified through the annual check-in - Completed Iowa Acuity Scale recommending higher intensive case management services.	Transitioning client's files will include a completed Iowa Acuity Scale present in client's file. Clients referred to Data to Care Program files will include:

Referral to Data to Care Program or Client Discharge	Clients being discharged should demonstrate one or more of the MOSS client discharge criteria: - Voluntary withdrawal from the service - Death of the client - Relocation outside the service area - Client otherwise lost to service (unable to locate after 3 months of attempts – MCM will complete the Diligent Search Care Plan/Assessment, and if appropriate refer the client to the Data to Care Program) - Severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the staff or unlikely to be helpful to the client.	- Completed Diligent Search Care Plan/Assessment. - Completed Data to Care Referral form. Discharged clients' files will include a completed Iowa Ryan White Part B Case Management Discharge Form. A copy of the completed Ryan White Part B Case Management Discharge Summary will be faxed to the IDPH.

4.0 Core Services Standards of Care

Standards provide a direction to the delivery of HIV services. They provide a framework for evaluating services and define the professional case manager's accountability to the public and to the client. Standards of care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by IDPH.

This section provides the standards of care for the Ryan White core services that are currently provided in Iowa. Refer to Appendix A or section 4.2 for a complete list of core services.

4.1 Format of Standards

Each of the standards is presented in the format below. Review the format and refer back to this section if you have any questions while reading the following standards.

Service Category – Each service category will have a brief description of the service category.

"Service units" – Each service category will have a "service unit" defined.

Key Activities – Each service category will have a bulleted list of key activities to be performed as part of the service.

The standard will then be broken down by "key activities" preformed and outlined in a chart format including the Standard, Criteria, and Documentation. See the table below for more information.

Key Activity
Purpose: Provides the purpose of the key activity

Standard	Criteria	Documentation
Minimum requirement that programs are expected to meet when providing services.	Specific activities required to meet the standard	Appropriate documentation required

4.2 Ryan White Core Services Definitions

The following services are defined as HRSA Ryan White Core Services.

Core Services:

Outpatient/Ambulatory Medical Care (Health Services) 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. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services

include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and screening of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Oral Health Care includes diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Early Intervention Services (EIS) include counseling individuals with respect to HIV; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV; periodic medical evaluations for individuals with HIV; and providing therapeutic measures.

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.

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

Home and Community-based Health Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate metal health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **not** included.

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

Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a

mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

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 provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical Case Management Services 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 treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic 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 including face to face, phone contacts, and any other forms of communication.

Substance Abuse Services Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e. alcohol, and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

4.3 Eligibility and Payer-of-Last-Resort Standards

All Core Services must adhere to the following standards regarding client eligibility and payer of last resort.

4.3.1 Eligibility Criteria/Determination

Purpose: Providers of Ryan White Core Services will determine, follow, and disseminate eligibility criteria.

Standard	Criteria	Documentation
Part B provider will develop eligibility criteria.	Eligibility criteria for Core Services will include: - income limits - award amount limits - award frequency limits - residency requirements	The Part B provider has eligibility criteria developed and incorporates criteria into Core Service delivery policies and procedures.
Part B provider will follow eligibility criteria.	Part B provider will follow eligibility criteria.	Part B provider has on file documentation that client meets eligibility criteria.

Documentation for client eligibility will be collected.	Eligibility criteria must include at a minimum: - HIV-positive status - Iowa residency - Income at or below 400% FPL Eligibility must be re-evaluated following the standard listed under each respective level of case management, or prior to receiving the service if documentation has not been collected within last six months.	Part B provider has on file documentation that client meets eligibility criteria. Documentation that client meets eligibility criteria is collected and present in client file.

4.3.2 Ensuring Payer of Last Resort

Purpose: Ryan White services must be used as payer of last resort. Agencies must require and maintain documentation that Core Service funds are used as a payer of last resort.

Standard	Criteria	Documentation
Assist clients with assistance to meet needs when all other options have been exhausted.	Applicants must agree to plan for self-sufficiency around need if assistance has been requested or received twice within a one-year period.	Financial goals will be added to the client's Care Plan if deemed necessary by criteria listed.

4.4 Outpatient/Ambulatory Medical Care

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. Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and screening 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). Such services may be delivered by appropriately licensed agency staff or may be delivered by community providers through a voucher or direct payment arrangement.

"Service units" of Outpatient/Ambulatory Medical Care services are documented per service provided (i.e., one visit equals one service unit) as "outpatient/ambulatory medical care" in CAREWare, with a corresponding dollar amount, if necessary.

Key Activities

- Eligibility determination

- Ensuring payer of last resort
- Providing access to treatment by licensed health care professionals
- Delivery of services
- Coordination and referral

Access to Treatment

Purpose: Provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

Standard	Criteria	Documentation
Clients will receive outpatient/ambulatory health services from appropriately licensed and credentialed providers.	Medical providers have a current license/certification for providing medical services in Iowa.	Part B provider has on file a copy of Iowa License or Certificate for every medical provider receiving payment.
Access should be provided in a timely manner.	Practices will have policies and procedures that facilitate timely, medically appropriate care. Ideally, practices will be able to see acutely symptomatic HIV-positive patients the same day or will facilitate appropriate referral to urgent care or the emergency department.	Medical providers' policies and procedures indicate how emergent, urgent, and acute needs of new and established patients are managed.

Delivery of Services

Purpose: The provision of outpatient/ambulatory services should be consistent with national guidelines regarding high quality, evidence-based HIV care.

Standard	Criteria	Documentation
The delivery of outpatient/ambulatory care should be consistent with Public Health Service (PHS) guidelines.	Quality assurance practices, as well as clinical policies and practices, should be consistent with PHS guidelines concerning: - Antiretroviral treatment for adults and adolescents - Maternal to child transmission - Management of HIV complications.	Medical providers of outpatient/ambulatory care should demonstrate overall compliance with the PHS guidelines. Any deviations from guidelines should be justified by specific client circumstances and evidence-based medical practices.
The provision of outpatient/ambulatory services are provided in an outpatient setting for allowable services.	Only allowable services are provided. Allowable services include: - Diagnostic testing - Early intervention and risk assessment - Preventative care and screening	Documentation that only allowable services are provided.

	- Practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions - Prescribing and managing of medication therapy - Education and counseling on health issues - Well-baby care - Continuing care and management of chronic conditions - Referral to and provision of HIV-related specialty care. To be allowable, the service cannot be provided in an emergency room, hospital, or any other type of inpatient treatment center.	Documentation that services were provided in an outpatient setting.

Coordination and Referral

Purpose: programs that do not directly provide outpatient/ambulatory medical care should actively facilitate the process and ensure clients have access to appropriate medical care.

Standard	Criteria	Documentation
Part B providers who do not directly provided outpatient/ambulatory medical care treatment should systemically provide access to services.	The Part B provider will initiate referrals that were agreed upon by the client and the provider. These may include: - Referring to a named agency, including the name of a contact person at the referral agency and an exact address - Assisting clients with making and keeping appointments - Identifying referral agency eligibility requirements - Assisting clients to gather required documents to bring to the appointment.	All of the elements of linked referrals should be documented in Case Notes and in Care Plan, as needed.
As appropriate, Part B providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's	Signed release of information forms are obtained, as necessary.	Signed release of information is present in the client's file.

needs and other important information to the service providers.		
The Part B provider will identify and assist in resolving any barriers clients may have that impede access.	The Part B provider will work with the client to identify barriers to referrals and facilitate access to referrals.	The Part B provider will document all barriers identified in the referral process and actions taken to resolve them in Case Notes and Care Plan, as needed.
The Part B provider will ensure clients are accessing needed referrals and services, and are following through with their referral plans.	Part B providers will utilize a Care Plan or a tracking mechanism to monitor completion of all linked referrals. Clients should receive prompt follow up to ensure that barriers to accessing needed services are addressed. The Part B provider will document when a client refuses to follow through on a referral.	The Part B provider will document follow-up activities and outcomes in Case Notes and Care Plan, as needed, and/or in other tracking mechanisms.

4.5 AIDS Drug Assistance Program (ADAP)

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

The ADAP manual is available to provide guidance regarding the ADAP program. The ADAP manual can be found on the Ryan White Part B Program's website. For additional guidance the ADAP office can be reached at 515-281-0296.

4.6 Oral Health Care

Oral Health care is the provision of routine and emergency dental care for persons living with HIV. This includes diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers. Such services may be delivered by appropriately licensed agency staff or may be delivered by community providers through a voucher or direct payment arrangement.

A "service unit" of Oral Health Care is documented per service provided (i.e., one dental visit equals one service unit) as "Oral Health Care" in CAREWare, with a corresponding dollar amount, if necessary.

Key Activities

- Eligibility determination
- Ensuring payer of last resort
- Providing access to treatment by licensed dentists

Access to Treatment

Purpose: To provide clients with the highest quality services through trained, experienced, and appropriately licensed and credentialed staff members.

Standard	Criteria	Documentation
Clients will receive oral health services from appropriately credentialed providers.	Dental providers have a current license/certification for providing oral health services in Iowa. Community providers will ensure participating dentists possess appropriate license, credentials, and expertise	Part B provider has on file a copy of Iowa License or Certificate for every dental provider receiving payment. Upon request by IDPH, a listing of all community dental providers receiving oral health funding through a subcontract or on an ad hoc basis shall be submitted.
Clients receive assistance to schedule and coordinate dental appointments.	Case manager shall assist client to schedule and coordinate all dental appointments as needed.	The case manager will document scheduling and coordination of appointments in Case Notes and Care Plan, as needed.
Oral health appointments are followed up by case manager.	Case manager shall follow up on all dental appointments to ensure clients maintain access to dental services.	The case manager will document outcome of follow up in Case Notes and Care Plan, as needed.

Expenditure Monitoring

Purpose: Oral Health Care assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of Oral Health Care assistance funding provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures of mental health that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance.	Evidence of tracking system.

No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Oral Health Care services.

Standard	Criteria	Documentation
Oral Health Care records will reflect compliance with the standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Oral Health Care services will maintain records for each client served.	Oral Health Care assistance records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher Oral Health Care services will be documented as a case note with corresponding service unit and in Care Plan, as needed.

4.7 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, co-insurance, co-payments, and deductible amounts.

Examples of allowable services billed to Health Insurance Premium & Cost-Sharing Assistance include co-payments for medications not covered by the ADAP formulary, mental health co-payments, etc.

A "Service unit" of Health Insurance Premium & Cost-Sharing Assistance is documented per service provided (i.e., one payment equals one service unit) as "Health Insurance Premium & Cost-Sharing Assistance" in CAREWare, with a corresponding dollar amount.

Key Activities

- Eligibility determination
- Ensuring payer of last resort
- Expenditure monitoring
- Records management

Expenditure Monitoring

Purpose: Health Insurance Premium & Cost-Sharing Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of Health Insurance Premium & Cost-Sharing Assistance funding provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures of Health Insurance Premium & Cost-Sharing that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance. The Part B provider must track use of funds to ensure the total combined amount per client must not exceed the determined award amount per contract year.	Evidence of tracking system.
No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Health Insurance Premium & Cost-Sharing Assistance.

Standard	Criteria	Documentation
Records will reflect compliance with the Health Insurance Premium & Cost-Sharing Assistance standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Health Insurance Premium & Cost-Sharing Assistance will maintain records for each client served.	Health Insurance Premium & Cost-Sharing records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher. Health Insurance Premium & Cost-Sharing Assistance services will be documented as a case note in CAREWare, with corresponding service unit and dollar amount.

4.8 Mental Health Services

Mental Health Services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized by the State of Iowa to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

A "service unit" of Mental Health is documented per service provided (i.e., one counseling session equals one service unit) as "Mental Health Services" in CAREWare, with a corresponding dollar amount.

Key Activities

- Eligibility determination
- Ensuring payer of last resort
- Providing access to treatment
- Coordination and referral
- Expenditure monitoring
- Records management

Access to Treatment

Purpose: provide clients with the highest quality service through trained, experienced, and appropriately licensed and credentialed staff members.

Standard	Criteria	Documentation
Clients will receive mental health services from appropriately licensed and credentialed providers.	Mental health providers have a current license/certification for providing Mental Health Services in Iowa.	Part B provider has on file a copy of Iowa License or Certificate for every mental health provider receiving payment.
Access should be provided in a timely manner.	Mental health providers will have policies and procedures that facilitate timely, medically appropriate care.	Mental health provider policies and procedures indicate how needs of clients are managed.

Coordination and Referral

Purpose: programs that do not directly provide Mental Health Services should actively facilitate the process and ensure clients have access to appropriate care. The referral process should include timely follow up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered as part of the referral process.

Standard	Criteria	Documentation
Part B providers who do not directly provided mental health	The Part B provider will initiate referrals that were agreed upon	All of the elements of linked referrals should be documented

services should systemically provide access to services.	by the client and the provider. These may include: - Referring to a named agency, including the name of a contact person at the referral agency and - An exact address - Assisting clients with making and keeping appointments - Identifying referral agency eligibility requirements - Assisting clients to gather required documents to bring to the appointment.	in Case Notes and in Care Plan, as needed.
As appropriate, Part B providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the mental health providers.	Signed release of information forms are obtained, as necessary.	Signed release of information is present in client file.
The Part B provider will identify and assist in resolving any barriers clients may have that impede access.	The Part B provider will work with the client to identify barriers to referrals and facilitate access to referrals.	The Part B provider will document all barriers identified in referral process and actions taken to resolve them in Case Notes and in Care Plan, as needed.
The Part B provider will ensure clients are accessing referrals and services, and are following through with their referral plan.	Part B providers will utilize the Care Plan or a tracking mechanism to monitor completion of all linked referrals. Clients should receive prompt follow up to ensure that barriers to accessing needed services are addressed. The Part B provider will document when a client refuses to follow through on a referral.	The Part B provider will document follow-up activities and outcomes in Case Notes, Care Plan, as needed, and/or through other tracking mechanisms.

Expenditure Monitoring

Purpose: Mental health assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of Mental Health Services funding provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures for Mental Health Services that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance.	Evidence of tracking system.
No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Mental Health services.

Standard	Criteria	Documentation
Mental Health Services records will reflect compliance with the standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Mental Health Services will maintain records for each client served.	Mental Health Services assistance records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher Mental Health Services will be documented as a case note with corresponding service unit, and in Care Plan, as needed.

4.9 Substance Abuse Services – Outpatient

Substance abuse services – outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (e.g., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

A "service unit" of Substance Abuse Services – Outpatient is documented per service provided (i.e., one treatment session equals one service unit) as "Substance Abuse: Outpatient" in CAREWare, with a corresponding dollar amount.

Key Activities

- Eligibility determination
- Ensuring payer of last resort

- Providing access to treatment
- Coordination and referral
- Expenditure monitoring
- Records management

Access to Treatment

Purpose: provide clients with the highest quality service through trained, experienced, and appropriately licensed and credentialed staff members.

Standard	Criteria	Documentation
Clients will receive Substance Abuse Services – Outpatient from appropriately licensed and credentialed treatment providers.	Treatment providers have a current license/certification for providing substance abuse treatment services in Iowa.	Part B provider has on file a copy of Iowa License or Certificate for every treatment provider receiving payment.
Access should be provided in a timely manner.	Treatment providers will have policies and procedures that facilitate timely, medically appropriate care.	Treatment provider policies and procedures indicate how needs of clients are managed.

Coordination and Referral

Purpose: programs that do not directly provide outpatient substance abuse treatment services should actively facilitate the process and ensure clients have access to appropriate care. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered as part of the referral process.

Standard	Criteria	Documentation
Part B providers who do not directly provide outpatient substance abuse treatment services should provide access to services through referrals.	The Part B provider will initiate referrals that were agreed upon by the client and the provider. These may include: - Referring to a named agency, with a the name of a contact person at the referral agency and an exact address - Assisting clients with making and keeping appointments - Identifying referral agency eligibility requirements - Assisting clients with gathering required documents to bring to the appointment.	All of the elements of linked referrals should be documented in Case Notes and the Care Plan, as needed.
As appropriate, Part B providers shall facilitate referrals by obtaining releases of information to permit provision	Signed release of information forms are obtained, as necessary.	Signed release of information is present in client's file.

of information about the client's needs and other important information to the treatment providers.		
The Part B provider will identify and assist in resolving any barriers clients may have that impede access.	The Part B provider will work with the client to identify barriers to referrals and facilitate access to referrals.	The Part B provider will document all barriers identified in the referral process and actions taken to resolve them in Case Notes and the Care Plan, as needed.
The Part B provider will ensure clients are accessing referrals and services, and following through with their referral plan.	Part B providers will utilize the Care Plan or a tracking mechanism to monitor completion of all linked referrals. Clients should receive prompt follow up to ensure that barriers to accessing services are addressed. The Part B provider will document when a client refuses to follow through on a referral.	The Part B provider will document follow-up activities and outcomes in Case Notes and the Care Plan, as needed, and/or through other tracking mechanisms.

Expenditure Monitoring

Purpose: Substance Abuse Services – Outpatient requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Agencies must be able to track the total amount of Substance Abuse Services – Outpatient funding provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures of mental health that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance.	Evidence of tracking system.
No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Substance Abuse Services – Outpatient.

Standard	Criteria	Documentation
Substance Abuse Services – Outpatient records will reflect compliance with the standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Substance Abuse Services – Outpatient will maintain records for each client served.	Substance Abuse Services – Outpatient records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher Substance Abuse Services – Outpatient will be documented in Case Notes with corresponding service unit and Care Plan, as needed.

5.0 Support Services Standards of Care

Standards provide a direction to the delivery of HIV services. They provide a framework for evaluating services and define the professional case manager's accountability to the public and to the client. Standards of Care are the minimum requirements that programs are expected to meet when providing HIV care and support services funded by IDPH.

This section provides the Standards of Care for the Ryan White Support Services that are currently provided in Iowa. Refer to Appendix A or section 5.2 for a complete list of Support Services.

5.1 Format of Standards

Each of the standards is presented in the format below. Review the format and refer back to this section if you have any questions while reading the following sections.

Service Category – Each service category will have a brief description of the service category.

"Service Units" – Each service category will have a "service unit" defined.

Key Activities – Each service category will have a bulleted list of key activities to be performed as part of the service.

The Standards of Care will then be broken down by "key activities" performed and outlined in a chart format including the Standard, Criteria, and Documentation. See the chart below for more information.

Key Activity
Purpose: Provides the purpose of the key activity

Standard	Criteria	Documentation
Minimum requirement that programs are expected to meet when providing services.	Specific activities required to meet the standard	Appropriate documentation required

5.2 Ryan White Support Services Definitions

The following services are defined as HRSA Ryan White Support Services.

Support Services:

Case Management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

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 Program related meetings, groups, or trainings.

Pediatric Developmental Assessment and Early Intervention Services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

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

Food Bank/Home-Delivered Meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies, such as hygiene items and household cleaning supplies, should be included in this item. This also includes vouchers to purchase food.

Health Education/Risk Reduction is the provision of services that educate clients about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients with HIV improve their health statuses.

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

Legal Services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, and interventions to ensure access to eligible benefits, including discrimination or breach-of-confidentiality litigation as it relates to Ryan White Program services. They do not include any services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistic Services include the provision of interpretation and translation services.

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

Outreach Services are programs that have as their principal purpose identification of people with undiagnosed HIV disease or identification of those who know their status but are not in care (i.e. case finding). They do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. 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 epidemiological data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency Planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or no longer able to care for them.

Psychosocial Services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. They may also include nutrition counseling provided by a non-registered dietitian, but they exclude the provision of nutritional supplements.

Referral for Health Care/Supportive Services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made with the non-medical case management system by a professional case manager, informally through support staff, or as part of an outreach program.

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

Respite Care is the provision of community or home-based, non-medical assistance designed to relieve the primary care giver responsibility for providing day-to-day care of a client with HIV.

Substance Abuse Services – Residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Treatment Adherence Counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV treatments by non-medical personnel outside of the medical case management and clinical setting.

5.3 Eligibility and Payer of Last Resort Standards

All Core Services must adhere to the following standards regarding client eligibility and payer of last resort.

5.3.1 Eligibility Criteria/Determination

Purpose: Providers of Ryan White Support Services will determine, follow, and disseminate eligibility criteria.

Standard	Criteria	Documentation
Part B provider will develop eligibility criteria.	Eligibility criteria for Support Services will include: - income limits - award amount limits - award frequency limits - residency requirements	The Part B provider has eligibility criteria developed and incorporates criteria into support service delivery policies and procedures.
Part B provider will follow eligibility criteria.	Part B provider will follow eligibility criteria.	Part B provider has on file documentation that client meets eligibility criteria.
Documentation for client eligibility will be collected.	Eligibility criteria must include at a minimum: - HIV-positive status - Iowa residency - Income at or below 400% FPL Eligibility must be re-evaluated following the standard listed under each respective level of case management, or prior to receiving the service if it has not been collected within last six months.	Part B provider has on file documentation that client meets eligibility criteria. Documentation that client meets eligibility criteria is collected and present in client's file.

5.3.2 Ensuring Payer of Last Resort

Purpose: Ryan White services must be used as payer of last resort. Agencies must require and maintain documentation that Support Service funds are used as a payer of last resort.

Standard	Criteria	Documentation
Assist clients with assistance to meet needs when all other options have been exhausted.	Applicants must agree to plan for self-sufficiency if assistance has been requested or received twice within a one-year period.	Financial goals will be added to client's Care Plan, if deemed necessary by criteria listed.

5.4 Emergency Financial Assistance

Emergency Financial Assistance is the provision of short-term payments to agencies or the establishment of voucher programs intended to assist persons living with HIV with emergency expenses. Direct emergency financial awards are not entitlements. Emergency financial assistance is meant to be short term, when no other resources are available. It should NOT duplicate, and should be coordinated with, the assistance provided by the Iowa ADAP. Clients should be actively linked to long-term support, including health insurance, Medicaid, Medicare, HOPWA, and other available programs. Emergency financial assistance may *not* be provided to clients in cash or cash equivalents (such as traveler's checks). No payment may be made directly to clients, family, or household members.

"Service units" of emergency financial assistance are documented per service provided (i.e., one disbursement equals one service unit) as "emergency financial assistance" in CAREWare, with a corresponding dollar amount.

Key Activities

- Eligibility determination
- Expenditure monitoring
- Records management

Eligibility Criteria/Determination

Purpose: Providers of emergency financial assistance services will determine, follow, and disseminate eligibility criteria. The standards listed below are in addition to the standards listed for eligibility criteria/determination listed in section 5.3.1.

Standard	Criteria	Documentation
Emergency Financial Assistance services are limited to the following types of needs: - Essential utilities - Health insurance (premiums, co-payments, deductibles, and coinsurance) - HIV-related medications (single occurrence, only short duration) - HIV-related outpatient/ambulatory care. This category includes co-payments and other fees related to those services - Food and essential household supplies, if there is no separate food bank at the provider	Part B provider will follow limitation on usage guidelines.	The Part B provider has on file documentation that funding was limited to the allowable usage categories.

- Transportation, if there is no separate medical transportation service available at the provider - Other services as approved by the IDPH		
Emergency Financial Assistance services must be limited to *short-term* support of the allowable usage categories.	Part B provider will assist the client in developing a financial plan to eliminate the need for Emergency Financial Assistance services after client has requested or received assistance twice within a one-year period. Part B provider will track utilization of assistance to ensure usage is short-term support of emergency needs.	Financial goals will be added to client's Care Plan, if deemed necessary by criteria listed. Evidence of tracking system.

Expenditure Monitoring

Purpose: Emergency Financial Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of emergency financial assistance funding provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures of Emergency Financial Assistance that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance.	Evidence of tracking system.
No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Emergency Financial Assistance.

Standard	Criteria	Documentation
Emergency Financial Assistance records will reflect compliance with the Emergency Financial Assistance standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Emergency Financial Assistance will maintain records for each client served.	Emergency Financial Assistance records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher. Emergency Financial Assistance services will be documented in Case Notes with corresponding service units and Care Plan, as necessary.

5.5 Food bank/Home-Delivered Meals

Food Bank/Home-Delivered Meals involve the provision of actual food or meals. It does not include finances to purchase food or meals, but it may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, should be included in this item. Nutritional supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician should be included in food bank expenditures.

"Service units" of food bank are defined as an instance of a client receiving food, a voucher for food, or other resources allowable under this services category and are documented per service provided as "food bank/home-delivered meal" in CAREWare, with corresponding dollar amount, if necessary.

Key Activities

- Eligibility determination
- Ensuring food safety
- Coordinating use of volunteers
- Records management

<u>Eligibility Criteria/Determination</u>

Purpose: Providers of Food Bank/Home-Delivered Meal services will determine, follow, and disseminate eligibility criteria. The standards listed below are in addition to the standards listed for eligibility criteria/determination listed in section 5.3.1.

Standard	Criteria	Documentation
Food Bank/Home-Delivered Meal services are limited to the following: - The provision of actual food items	Part B provider will follow limitation on usage guidelines.	The Part B provider has on file documentation that the services provided are limited to the allowable usage categories.

- The provision of nutritional supplements - The provision of hot meals - A voucher program to purchase food. Services may also include the provision of non-food items that are limited to: - Personal hygiene products - Household cleaning supplies.		
Part B provider will follow and disseminate policy and procedures for use of vouchers.	Staff is made aware of and provided a copy of policies and procedures related to distribution of vouchers. Clients will be made aware of and provided a copy of policies and procedures related to receiving vouchers: - Purchase of alcohol, tobacco, illegal drugs or firearms is prohibited - Vouchers may not be redeemed for cash.	The Part B provider has on file documentation of the policies and procedures. The client record should include evidence of client signed the acknowledgement of the use of the voucher policy.

Food Safety

Purpose: The agency shall adhere to all federal, state, and local public health food safety regulations to ensure the health and safety of clients.

Standard	Criteria	Documentation
Part B providers will obtain appropriate licensure/ certification for Food Bank/Home-Delivered Meals, where required under State or local regulations.	The Part B provider maintains any required licensure/ certifications at all times while providing services. The Part B provider has a procedure to ensure all required licensure/certifications are up to date.	Part B provider has on file documentation of any required licensure/certification.
The Part B provider shall adhere to all federal, state, and local public health food safety regulations.	The program meets all requirements of the local health department for food handling and storage.	Part B provider will maintain on file records of local health department food handling/food safety inspections.

Use of Volunteers

Purpose: Providers may use volunteers to expand program capacity to provide Food Bank/Home-Delivered Meals.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	All volunteers who have client contact will be given orientation prior to providing services. All volunteers will be supervised by qualified program staff.	Orientation curriculum on file at provider agency. Evidence of: - Volunteer application - Training - Supervision Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

Records Management

Purpose: Services provided link clients with access to nutritional needs. Documentation is written proof or evidence that client received Food Bank/Home-Delivered Meal services. Vouchers must be securely stored and securely transferred with limited staff access. Providers will keep these vouchers in locked and secured storage until they are given to clients.

Standard	Criteria	Documentation
Records will reflect compliance with the Food Bank/Home-Delivered Meals standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Food Bank/Home-Delivered Meal services will maintain records for each client served.	Food Bank/Home-Delivered Meals records include: - Date client received assistance - Documentation that the client meets eligibility criteria. -Copy of check or Voucher. Food Bank/Home-Delivered Meal services will be documented as a Case Note with corresponding service unit and in Care Plan, as needed.
Part B provider will develop policy to ensure security of vouchers.	Part B providers have policy ensuring security of vouchers. Staff is aware of policy and procedures.	Part B provider has policy and procedures on file.

5.6 Housing Services

Housing Services are the provision of short-term payments to support people living with HIV to obtain, secure, and/or maintain adequate housing. Housing assistance is meant to be short term, when no other resources are available. It should NOT duplicate, and should be coordinated with, the assistance provided by the Housing Opportunities for Persons with AIDS (HOPWA) program. Assistance should support housing options that are feasible for the client to sustain beyond support provided through Ryan White funding. Housing assistance may *not* be provided to clients in cash or cash equivalents (such as traveler's checks). No payment may be made directly to clients, family, roommates, or household members.

"Service units" of housing services are documented per service provided (i.e. one disbursement equals one service unit) as "Housing Services" in CAREWare with a corresponding dollar amount.

Key Activities

- Eligibility criteria
- Application completion
- Expenditure monitoring
- Records management

Eligibility Criteria/Determination

Purpose: Providers of housing assistance services will determine, follow, and disseminate eligibility criteria. The standards listed below are in addition to the standards listed for eligibility criteria/determination listed in section 5.3.1.

Standard	Criteria	Documentation
Housing Assistance services are limited to the following types of needs: - Essential utilities (gas, electric, water, propane) - Essential utility deposit - Past-due essential utilities - Rent - Past-due rent - Rental deposit - First month's rent - Rental application and/or background check fees - Lot rent - Hotel/Motel voucher - Other services as approved by the IDPH	Part B provider will follow limitation on usage guidelines.	The Part B provider has on file documentation that funding was limited to the allowable usage categories. Ryan White Short Term Housing Assistance Application is completed and in client file with all required supporting documents.

Eligibility criteria for Housing Assistance services will include FPL maximum of 400%.	Part B provider will provide services to eligible clients under the FPL guideline.	Part B provider has on file documentation of client FPL. Ryan White Short Term Housing Assistance Application is completed and in client file with all required supporting documents.
Evidence of tenancy or residency.	Client must demonstrate that they are either the named tenant on the lease/account, are a resident in the dwelling, or have a responsibility to pay rent.	Copy of documentation present in client file.
Housing Assistance services must be limited to *short-term* support of the allowable usage categories.	Part B provider will limit assistance to six times per calendar year. Part B provider will assist the client in developing a financial plan to eliminate the need for housing services after client has requested or received assistance three times within a one year period, if not before. Part B provider will track utilization of assistance to ensure usage is short-term support of housing assistance needs.	Part B provider will track usage in CAREWare. Financial goals will be added to clients Care Plan if deemed necessary by criteria listed. Evidence of tracking system.

Application Completion

Purpose: Housing Assistance requires completion of the Ryan White Short Term Housing Assistance Application. All clients receiving housing assistance must have a completed application present in their file for each request.

Standard	Criteria	Documentation
Part B providers will complete Ryan White Short Term Housing Assistance Application for each housing assistance request.	The Part B provider has a procedure to complete application.	Application is complete and present in client file.
Part B providers collect all required supporting documents.	Part B provider will collect all required documents based on the type of assistance request.	Required supporting documents are present in client file with Ryan White Short Term Housing Assistance Application.

	Documentation requirements include: For rent, past-due rent, rental deposit, first months' rent, lot rent, or rental application and/or background check fees: - rental agreement/lease - any additional forms your financial department requires (i.e. W-9) For utilities, utility deposit, past-due utilities: - utility bill - any additional forms your financial department requires (i.e. W-9) For hotel/motel vouchers: - statement including costs - any additional forms your financial department requires (i.e. W-9)	

Expenditure Monitoring

Purpose: Housing Assistance requires careful monitoring of expenditures to ensure funding will be available throughout the program year. Funded agencies must be able to track the total amount of housing assistance provided.

Standard	Criteria	Documentation
Part B providers will effectively utilize and allocate expenditures.	The Part B provider has a procedure to monitor/manage expenditures of Housing Assistance that ensures funding will be available throughout the program year. The Part B provider will track utilization of assistance.	Evidence of tracking system.
No payment may be made directly to clients, family, or household members.	Provide mechanism through which payment can be made on behalf of the client.	Part B provider will produce and maintain documentation ensuring payments were made to appropriate vendors.

Records Management

Purpose: Documentation is written proof or evidence that client received Housing Assistance.

Standard	Criteria	Documentation
Housing Assistance records will reflect compliance with the Housing assistance standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Housing Assistance will maintain records for each client served.	Housing assistance records include: - date client received assistance - documentation that the client meets eligibility criteria - copy of check or voucher. Housing assistance services will be documented in case notes with corresponding service unity and dollar amount.

5.7 Linguistic Services

Linguistics Services include the provision of interpretation and translation services.

"Service units" of Linguistic Services are defined as an instance of a client receiving interpretation or translation services and are documented per service provided as "linguistic services" in CAREWare, with corresponding dollar amount, if necessary.

Key Activities

- Eligibility determination
- Providing linguistically appropriate services
- Assessment of interpretation and/or translation needs
- Coordinating use of volunteers
- Records management

Provide linguistically appropriate services

Purpose: Providers of Ryan White Part B services will provide services that are linguistically appropriate.

Standard	Criteria	Documentation
Part B providers must assure the competence of language assistance provided to clients limited in English proficiency by interpreters and bilingual staff. Family and friends should not be used to provide translation	Part B providers ensure access to services for clients with limited English skills in one of the following ways: - Bilingual staff who can communicate directly with clients in preferred language	Part B providers document access to services for clients with limited English skills through the following: - For bilingual staff, résumés on file demonstrating bilingual proficiency and documentation

services (except on request by the patient/consumer).	- Face-to-face interpretation provided by qualified staff, contract interpreters, or volunteer interpreters - Telephone interpreter services. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent. The family member or friend must be able to communicate fluently in both English and the native language of the client.	on file of training on the skills and ethics of interpreting - Copy of certifications on file for contract or volunteer interpreters - Listing/directories on file for telephone services - Family/friend interpretation consent form signed by the client and maintained in client's file.

Assessment of interpretation and/or translation needs

Purpose: the purpose of the assessment is to evaluate the client's interpretation and/or translation needs and to eliminate barriers to accessing services. Information obtained from the assessment is used to assist in accessing services.

Standard	Criteria	Documentation
Working collaboratively with the client and/or client's support person, the Part B provider conducts an assessment of clients interpretation and/or translation needs.	The Part B provider conducts an assessment of client's interpretation and/or translation needs or when there is an access barrier.	The Part B provider will document assessment in client's file and Case Notes.
Working collaboratively with the client and/or client's support person, the Part B provider assesses the appropriate method to access interpretation services.	The Part B provider and client identify appropriate method to access services (i.e., telephone interpretation, bilingual staff member, etc.).	Chosen method is documented by the case manager in the client's file and Case Notes.

Use of Volunteers

Purpose: Providers may use volunteers in order to expand program capacity for Linguistic Services.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	All volunteers will be given orientation prior to providing services. All volunteers will be supervised by qualified program staff.	Orientation curriculum on file at provider agency. Orientation curriculum reviewed by IDPH prior to implementation.

		Evidence of: - Volunteer Application - Training - Supervision Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.
Part B providers will maintain a release of information signed by the client.	The Part B provider must obtain a written and signed release of information.	Signed release of information is present in client's file.

Records Management

Purpose: Documentation is written proof or evidence that client received Linguistic Services.

Standard	Criteria	Documentation
Linguistic Services records will reflect compliance with the standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B providers of Linguistic Services will maintain records for each client served.	Linguistic Services records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Copy of check or voucher, if applicable. Linguistic services will be documented as a Case Note in CAREWare, with corresponding service unit and dollar amount, if applicable.

5.8 Medical Transportation Services

Medical Transportation Services are conveyance services provided directly or through a voucher to a client so that he or she may access health services. Medical Transportation Services are used to provide transportation for eligible clients to core medical and support services. Medical Transportation Services must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service. Use of van, taxi vouchers, bus tokens, bus passes, gas cards, staff member or volunteers is acceptable.

A Medical Transportation "service unit" is defined as an instance where a client's request for assistance is fully or partially satisfied using vouchers, gas cards, payments to an outside vendor, bus tokens, or transportation delivered by agency staff or volunteers. It should be documented as "medical

transportation" in CAREWare, with a corresponding dollar amount, if applicable. If staff time is used to transport a client, the service should be entered in the category in which that staff member is funded, and 15-minute increments should be used.

Key Activities

- Eligibility determination
- Ensuring payer of last resort
- Assessment and reassessment of transportation needs
- Providing medical transportation
- Coordinating use of volunteers
- Records management

Assessment and Reassessment

Purpose: the focus of the assessment is to evaluate the client's transportation needs and to eliminate barriers to accessing services. Information obtained from the assessment is used to assist in accessing services.

Standard	Criteria	Documentation
Working collaboratively with the client, the case manager conducts an assessment of the client's transportation needs.	The case manager conducts an assessment of the client's transportation needs at the client's request or when there is an access barrier. The case manager should employ reasonable due diligence to evaluate the appropriateness of the transportation being requested by the client.	The case manager will document assessment in Case Notes.
Part B provider will follow and disseminate transportation policy and procedures.	As part of the assessment process, case managers should review the provider's transportation policies and procedures with the client.	Part B provider has on file documentation of transportation policies and procedures.

Providing Medical Transportation Services

Purpose: Providers should provide or make arrangements for the safest, most cost-effective means of medical transportation to accommodate access to primary medical care or other core or support services. Medical Transportation Services may involve public transit, commercial transit, volunteers, and private transportation.

Standard	Criteria	Documentation
Working collaboratively with the client, the Part B provider will accommodate safe, cost-effective access to primary medical care, or other core or support services.	Part B providers should evaluate the type of medical transportation best suited to the needs of the client. Safety and cost effectiveness should be primary concerns. If staff or volunteers are used as drivers, the driver must demonstrate that he/she maintains the following: - A current, valid Iowa Driver's License, with a copy kept on file - Vehicle liability insurance coverage on their vehicle - Current Iowa registration and license plates (for staff and volunteers). Staff and volunteers who transport clients understand their responsibilities and obligations in the event of an accident, including the extent of their liability.	Part B provider records must include the following documentation: - Evidence of valid driver's license for all staff and volunteers providing direct transportation - Evidence of vehicle liability insurance - Evidence of Iowa vehicle registration - Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each staff or volunteer that provides medical transportation.

Use of Volunteers

Purpose: Providers may use volunteers and peers in order to expand program capacity for Medical Transportation Services.

Standard	Criteria	Documentation
Volunteers will receive appropriate orientation, training, and supervision.	All volunteers who have client contact will be given orientation prior to providing services. All volunteers will be supervised by qualified program staff.	Orientation curriculum on file at provider agency. Orientation curriculum reviewed by IDPH prior to implementation. Evidence of: - Volunteer application - Training - Supervision Signed and dated form on file that outlines responsibilities,

		obligations, and liabilities of each volunteer.

Records Management

Purpose: The records relating to Medical Transportation Services should document that such services were used to link clients with health care, psychosocial services, and other service needs. Documentation is written proof or evidence that the client received transportation assistance. Vouchers and tokens/coupons must be securely stored and securely transferred with limited staff access. Providers will keep these vouchers and tokens/coupons incentives in locked and secured storage until they are given to clients.

Standard	Criteria	Documentation
Part B providers will develop a policy and procedure documenting transportation services utilized.	Part B provider will track the utilization of Medical Transportation Services. This includes utilization of vouchers, tokens/coupons, passes, gas gift cards, and staff and volunteer time.	Medical Transportation Services records include: - Date client received assistance - Documentation that the client meets eligibility criteria - Amount of assistance received (if applicable).
Medical Transportation Services records will reflect compliance with the Medical Transportation Services standards outlined above. Records should be complete, accurate, confidential, and secure.	Part B provider will track the utilization of Medical Transportation Services on a per-client basis.	Medical Transportation Services will be documented as a Case Note in CAREWare, with corresponding service unit and dollar amount, if applicable.

5.9 Psychosocial Support Services (outside BCM)

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 for individuals who are living with HIV. This service includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements. Psychosocial support services help clients empower themselves and develop effective strategies for living healthy lives. Through one-on-one interactions and in small groups, these services support a client's engagement in health care and provide opportunities for education, skills building, and emotional support in a respectful environment. The standards in this section are not intended as standards for the case management level Brief Contact Management (BCM) which is billed to Psychosocial Support Services. For BCM standards please see page 37 of this manual.

"Service units" of Psychosocial Support Services are documented in 15-minute increments as "psychosocial support" in CAREWare.

Key Activities

- Eligibility determination
- One-on-one interactions
- Providing access to small-group sessions
- Disseminating newsletters
- Providing access to nutrition counseling provided by non-registered dietitian
- Coordinating use of volunteers
- Making referrals

One-on-one Interactions

Purpose: Providers of Psychosocial Support Services may deliver one-on-one interventions for PLWH that include topics applicable to the target population and focus on empowerment, self-advocacy, and medical self-management.

Standard	Criteria	Documentation
Psychosocial Support Services providers will offer client-driven, medically accurate, individualized sessions to improve quality of life for participants.	Psychosocial one-on-one participants will receive support concerning: - Access to health and other benefits - Developing coping skills - Reducing feelings of social isolation -Increasing self-determination and self-advocacy.	Provision of one-on-one support services is documented as Case Note with CAREWare, with a corresponding service unit, including: - Date - Duration (service units) - General topics discussed - Activities conducted - Goals and objectives achieved - Referrals made.

Groups

Purpose: Providers of Psychosocial Support Services may deliver group programs for PLWH that include topics applicable to the target population, focusing on empowerment, self-advocacy, and medical self-management.

Standard	Criteria	Documentation
Part B providers will offer a client-driven, medically accurate group to help improve the quality of life for participants.	Group participants will receive support concerning: - Access to health and other benefits - Developing coping skills -Reducing feelings of social isolation - Increasing self-determination and self-advocacy.	Part B provider will maintain group records that include: - Dated sign-in sheets - Number of participants attended - Name and title of group facilitator - Location of group - Copies of materials or handouts - Summary of topics discussed

		- Activities conducted - Goals and objectives achieved during group sessions. A Case Note and corresponding service unit will be entered in CAREWare stating the client participated in a psychosocial support group.

Newsletters

Purpose: Psychosocial Support providers may develop newsletters for PLWH that include topics applicable to the target population and focus on empowerment, self-advocacy, and medical self-management.

Standard	Criteria	Documentation
The Part B provider will develop a client-driven medically accurate newsletter.	Medical information included in the newsletter must provide the original source of the information.	Programs will maintain the following required documentation for newsletters: - Copies of newsletters produced - Number distributed - Copies of original source of all medical information. A Case Note and corresponding service will be entered in CAREWare stating the client was sent a psychosocial support newsletter.

Nutrition Counseling

Purpose: Psychosocial Support providers may include nutrition counseling provided by a non-registered dietitian.

Standard	Criteria	Documentation
The Part B provider will deliver nutritional counseling by a non-registered dietitian.	Nutritional counseling should adhere to generally accepted professional practices. Information developed or distributed must provide the original source of the information. Funds may not be used for provision of nutritional	Personnel files should include documentation of credentials of staff or volunteers delivering nutritional counseling. Provision of nutritional counseling is documented as a Case Note in CAREWare, with a corresponding service unit, including: - Date

	supplements (nutritional supplements provided by a non-registered dietitian are allowed under Food Bank/Home-Delivered Meal services).	- Duration - General topics discussed - Activities conducted - Goals and objectives achieved during nutritional counseling sessions.

Use of Volunteers

Purpose: Providers may use volunteers and peers to expand program capacity for Psychosocial Support services. With harm reduction as a foundation, Psychosocial Support services delivered by staff, volunteers, and/or peer support helps clients access health and benefit information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve quality of life for the participants.

Standard	Criteria	Documentation
Volunteers and peers will receive appropriate orientation, training, and supervision.	All volunteers and peers who have client contact will be given orientation prior to providing services. All volunteers and peers will be supervised by qualified program staff. Supervisor routinely evaluates Psychosocial Support services.	Orientation curriculum is on file at provider agency. Orientation curriculum is reviewed by IDPH prior to implementation. Evidence of: - Volunteer/peer application - Training - Supervision. Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

Referral

Purpose: Psychosocial support is not intended to address highly complex behavioral health, case management, or mental health issues. If necessary, referrals should be made to a more appropriate service. Referrals should be appropriate to client situation, lifestyle, and need.

Standard	Criteria	Documentation
The Part B provider will develop referral resource to make available the full range of additional services to meet the needs of clients.	Part B provider will develop and maintain comprehensive referral list for full range of services.	Referral list will be maintained, updated, and kept on file.
Part B providers will demonstrate active collaboration with other agencies to provide referrals to	Part B provider will collaborate with other agencies and providers to provide effective, appropriate referrals.	Memoranda of Understanding (MOU) with service providers is on file.

the full spectrum of HIV-related and other services.		
Each client receiving Referral Services will receive referrals to those services critical to achieving optimal health and wellbeing.	The Part B provider will support the client to initiate referrals that were agreed upon by the client and provider. The Part B provider will follow-up with client to ensure services were accessed.	The Part B provider will document all referrals and follow-up as a Case Note in CAREWare, with corresponding service unit.

5.10 Outreach Services (outside MOSS)

Outreach Services include both maintenance and recruitment activities that promote access to and continuation of appropriate services at the earliest possible stage of HIV disease. These activities often occur outside the walls of the traditional care and treatment system to promote access to and engagement in appropriate services for PLWH. Outreach services will ultimately reduce the number of PLWH who are not accessing the service delivery system. Outreach Services target populations who are at risk of, or a have fallen out of care. They may be newly diagnosed, or they may have discontinued care or support services months or years in the past. The purpose is to maintain, connect, or re-connect people to care and case management services. The standards in this section are not intended as standards for the case management level Brief Contact Management (BCM) which is billed to Psychosocial Support Services. For BCM standards please see page 37 of this manual.

"Service units" of outreach services are documented in 15 minute increments as "outreach" in CAREWare.

Key Activities

- Eligibility determination
- Identification of clients out of care n
- Providing information/education
- Assessing needs
- Maintaining contact
- Making referrals
- Engagement and retention activities
- Coordinating use of volunteers/peers

Client Identification

Purpose: Depending on the type of outreach, this service should identify people who are currently engaged in care and are at risk of falling out of care, or people who are aware of their HIV-positive serostatus, but who have no recent history of accessing core, support, or medical services.

Standard	Criteria	Documentation
Medical case management, non-medical case management, and brief contact management should identify clients who are at risk of falling out of care.	Clients at risk of falling out of care should be referred to Outreach Services to ensure client maintains engagement in core, support, and/or medical services.	Referrals to outreach services are documented as a Case Note in CAREWare.
Working collaboratively with local HIV prevention programs, medical providers, other RW providers, and IDPH to identify clients who are aware of their HIV-positive serostatus but not in care.	Part B providers should strive to identify those who could benefit from additional HIV care and treatment services.	Recruitment plans and strategies should demonstrate a systematic, evidence based approach to client identification.
Outreach Services programs must be planned and delivered in coordination with state and local HIV outreach programs.	Outreach efforts should support, but not duplicate, existing efforts by HIV providers.	Inventory of other Outreach Services providers and activities and a Memorandum of Understanding should be on file at the provider agency.

Providing Information/Education

Purpose: Outreach service providers will give clients and potential clients clear, factual information suited to their needs.

Standard	Criteria	Documentation
Outreach Services will include information and education about HIV and the HIV service delivery system.	Outreach Services protocols and materials must, at a minimum, address (based on the type of Outreach Services provided): -The importance of accessing HIV care -Availability of HIV medical care, including means of financing such care -The availability of other RW core and support services -Preventing the further spread of HIV through sexual and injection drug use behaviors -The importance of adhering to HIV medication and remaining in HIV care -Addressing other barriers and issues that challenge ongoing care and/or self-management.	Written materials and outreach protocols should demonstrate the required components.

Referral

Purpose: Referral should be appropriate to client situation, lifestyle, and need.

Standard	Criteria	Documentation
Each client receiving Outreach Services will receive referrals to those services critical to achieving optimal health and wellbeing and will receive assistance to help problem solve when barriers impede access.	The outreach worker will identify any needed referrals and provide client with information. The outreach worker will work with the client to determine barriers to referrals and facilitate access to referrals. Need for more intensive services (such as case management) should be systematically assessed while client is receiving Outreach Services.	The outreach worker will document all referrals as a case note in CAREWare, with a corresponding service unit. The Part B provider will establish processes, conduct follow up, and measure outcomes of referrals made. The Part B provider should establish protocols for assessing need for more intensive services and for documentation of referral follow up on such referrals. An Iowa Acuity Scale is not required, but may be conducted, if deemed appropriate.

Engagement and Retention

Purpose: Depending on the type of Outreach Services, programs will develop engagement and retention policies to ensure that every reasonable effort is made to bring or retain at-risk clients in care. Engagement and retention activities focus on clients who have fallen out of care or are at risk of falling out of care, and those clients aware of their HIV status but not currently in care. Activities can include telephone calls, letters, e-mails, text messages, and face-to-face visits.

Standard	Criteria	Documentation
Part B provider will ensure that every reasonable effort is made to bring or retain at-risk clients in care.	HIV outreach programs will develop engagement and retention policies and procedures.	Engagement and retention policies and procedures should be on file at the Part B provider agency.

Use of Volunteers

Purpose: Providers may use volunteers and peers in order to expand program capacity for Outreach Services. With harm reduction as the foundation, Outreach Services help clients to access health and benefit information, increase self-determination and self-advocacy, helping improve quality of life for the participants.

Standard	Criteria	Documentation
Volunteers and peers will receive appropriate orientation, training, and supervision.	All volunteers and peers who have client contact will be given	Orientation curriculum on file at Part B provider agency.

	orientation prior to providing services. All volunteers and peers will be supervised by qualified program staff. Supervisor routinely evaluates Outreach Services.	Orientation curriculum reviewed by IDPH prior to implementation. Evidence of: - Volunteer/peer application - Training - Supervision. Signed and dated form on file that outlines responsibilities, obligations, and liabilities of each volunteer.

5.11 Referral for Health Care/Supportive Services

Referral for Health Care/Supportive Services is the act of directing a client to services in person or through telephone, written, or other type of communication. Referrals are generally made by support staff. Referrals made by case managers are documented in the appropriate tier of case management.

"Service unit" of Referral for Health Care/Supportive Services are documented in 15 minute increments as "Referral for Health Care" in CAREWare.

Key Activities

- Eligibility determination
- Making active referrals
- Making passive referrals

Active Referral

Purpose: Referral should be appropriate to client situation, lifestyle, and need. The referral process should include timely follow up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered as part of the referral process.

Standard	Criteria	Documentation
Each client receiving referral services will receive referrals to those services critical to achieving optimal health and well-being.	The Part B provider will initiate referrals that were agreed upon by the client and the provider which may include: - Referral to a named agency - The name of a contact person at the referral agency - An exact address - Assisting clients with making and keeping appointments	All of the elements of linked referrals should be documented as a Case Note in CAREWare, with corresponding service unit.

	- Identifying referral agency eligibility requirements - Assisting clients to gather required documents to bring to the appointment.	
As appropriate, Part B providers shall facilitate referrals by obtaining releases of information to permit provision of information about the client's needs and other important information to the referred agency.	Signed release of information forms are obtained as necessary.	Signed release of information is present in the client's file.
The Part B provider will identify and assist in resolving any barriers clients may have that impede access.	The Part B provider will work with the client to identify barriers to referrals and facilitate access to referrals.	The Part B provider will document all barriers identified in referral process and actions taken to resolve them as case notes in CAREWare.
The Part B provider will ensure clients are accessing needed referrals and services, and in following through with their referral plan.	Part B providers will utilize a tracking mechanism to monitor completion of all linked referrals. Clients should receive prompt follow up to ensure that barriers to accessing needed services are addressed. The Part B provider will document when a client refuses to follow through on a referral.	The Part B provider will document follow-up activities and outcomes as Case Note in CAREWare and in the client's file.

Passive Referral

Purpose: Referrals should be to secure the needed care and services, not just the provision of information. Referrals should be appropriate to client situation, lifestyle, and need.

Standard	Criteria	Documentation
The Part B provider will develop referral resources to make available the full range of additional services to meet the needs of their clients.	Part B provider will develop and maintain comprehensive referral lists for full range of services.	Comprehensive referral list on file.
Part B providers will demonstrate active	Part B provider will collaborate with other agencies and	Memoranda of Understanding with services providers on file.

collaboration with other agencies to provide referrals to the full spectrum of HIV-related and other needed services.	providers to provide effective, appropriate referrals.	
Each client receiving Referral Services will receive referrals to those services critical to achieving optimal health and well-being.	The Part B provider will support the client to initiate referrals that were agreed upon by the client and the provider.	The Part B provider will document all referrals made to the client as a Case Note in CAREWare.

6.0 Payer of Last Resort

The Ryan White Program is a “payer of last resort,” meaning that funds may not be used for any item or service “for which payment has been made or can reasonably be expected to be made” by another payment source (Sections 2605(a) (6), 2617(b) (7) (F), 2664(f) (1) and 2671(i) of the Public Health Service Act). Ryan White funds may be used to complete coverage that maintains PLWH in care when the individual is either underinsured or uninsured for a specific allowable service. Service providers must assure that reasonable efforts are made to secure non –Ryan White funds whenever possible for services to individual clients. Part B providers are expected to vigorously pursue eligibility for other funding sources to extend finite Ryan White grant resources.

7.0 CAREWare

Iowa CAREWare is a secure, centralized, software application designed to report client-level data from HIV programs funded through Part B and Part C of the Ryan White HIV/AIDS Program. Ryan White funds are used in Iowa to support core medical and essential support services. Iowa CAREWare is used to report information about clients served by providers funded through the IDPH. This section is meant as a brief overview, please refer to the CAREWare User Guide for detailed procedures regarding CAREWare.

All Part B providers are required to utilize CAREWare to track and report client-level data. If you need access to CAREWare, please review the Desktop Guide and/or contact Karen Quinn.

7.1 Data Entry Policy

Part B providers are required to enter all data in the following tabs within 10 business days of initial client enrollment and/or changes to client information.

Part B providers are required to enter all Services and Case Notes within 3 business days of the date of service.

7.2 Required Tabs/Fields

Part B providers are required to complete the following tabs/fields:

<u>Demographics Tab</u>

First Name (No nicknames)
Middle Name (optional)
Last Name
Date of Birth
Gender
Sex at Birth
Address (If homeless, not required- please document)
City
State
Zip Code
County
Phone Number (If none, not required)
HIV Status
HIV+ Date
AIDS Date (If applicable)
HIV Risk Factor (this data element is the client's initial risk factor for HIV infection)

Report all of the response categories that apply:

- *Males who have sex with male(s) (MSM)* should be checked if a male client indicates sexual contact with other men. This should be checked regardless of sexual orientation (e.g. if a male client identifies as heterosexual but reports having sex with men).
- *Injection drug user (IDU)* should be checked when the client reports the use of intravenous drugs.

- *Hemophilia/coagulation disorder* should be checked when the client has been diagnosed with Hemophilia or another blood clotting disorder.
- *Heterosexual contact* should be checked when a client reports sexual contact with a person of the opposite sex who is HIV+ or is at an increased risk of HIV infection.
- *Perinatal Transmission* should be checked when a client was infected while in the mother's womb during gestation. This should also be selected if the client is under the age of 2, and the HIV status is still undetermined.
- *Receipt of transfusion of blood, blood components, or tissue* should be checked when the client was the recipient of a tainted blood or tissue product that resulted in their HIV diagnosis.
- *Risk factor not reported or not identified* should be checked if the client's risk factor is unknown. This category also refers to HIV-affected clients who do not have a risk factor.

Ethnicity
- Any subgroups that may apply

Race
- Any subgroups that may apply

Common Notes are shared across all providers that serve the client. Common notes should only include information that all providers need to know. Common notes are often used to communicate information between the Ryan White Provider and the ADAP office. Common Notes are not required.

Service Tab

Year
Vital Status
Deceased Date (if applicable)
Enrl. Status
Enrl. Date
Case Closed (if applicable)

Annual Review Tab

Primary Insurance
Other Insurance (If applicable)
Primary HIV Medical Care
Housing/Living Arrangement
Household Income
Household Size

Encounters
Within the Encounter tab, the Labs tab must be completed. Within the Labs tab, the Ryan White Provider must enter the clients CD4 and Viral Load information.

7.3 Services and Case Notes

Ryan White services are tracked and reported by each Part B provider. Part B providers are required to enter all Ryan White services in CAREWare, along with a corresponding service unit and Case Note.

Each funded service is listed in the “Service” tab of CAREWare. Service units are reported in 15-minute increments OR as a one-time service, based on the service provided. Please see each Ryan White service standard for the correct way to enter in CAREWare.

Along with the service, a Case Note must be entered. The Case Note provides a narrative format for Part B providers to document details of the service provided. A Case Note must contain the date, the author, and a brief narrative. Case Notes can only be viewed by the Part B provider who entered the note and the IDPH.

Each service entered must have a corresponding Case Note. Services and Case Notes must be entered within three business days of the service date.

8.0 File Maintenance

Part B providers are required to maintain a file on site for all clients who access Part B services through their agency. Client files must be kept in a confidential, secure, and locked space with access limited only to the case manager, the case manager's supervisor, and any other program staff. The IDPH may access client files at any time.

Client files must include client information including but not limited to the documents required for the service received. All documentation must be legible, kept in an organized manner, and available for administrative review as needed. Client files must be kept for seven (7) years on all closed or inactive clients.

8.1 Standard Format

Each Part B provider is required to develop and maintain a standardized format for client files. This format must be consistent across all Ryan White Part B clients within the provider. The IDPH recognizes that each Part B provider offers different services, and therefore will have varying needs for client files. Therefore, the IDPH does not require a statewide standardized format for client files. However, a standardized format within each Part B provider is required. The standardized format must include a place for:

- Iowa Ryan White Part B Application
- AIDS Drug Assistance Program (ADAP) Application and supporting documents
- Financial documentation
- Other required documentation, such as the Case Management Enrollment form, releases of information, Etc.

8.2 General Maintenance

All documentation must be legible, kept in an organized manner, and available for administrative review as needed. Client files must remain clear of hand written case notes, sticky notes, and loose paperwork. All documents must be organized in accordance to the Ryan White provider's standardized format.

8.3 Archiving

Due to the nature of the Ryan White Program and HIV, some clients may maintain eligibility and access services for many years. There is no time limit for accessing services through Ryan White as long as a client continues to meet the eligibility requirements of the program. This can cause an administrative dilemma due to the amount of paperwork and requirement that records are kept for seven years.

Archiving a portion of a client's file is an option to reduce the amount of paperwork kept in the client's current Ryan White file. If a Part B provider chooses to archive client files, a standard format should be

developed for archived files. This standard should be used across the Part B provider. The preferred format is to organize the archived file in chorological order.

It is important that certain information remain in the client's current file. This information includes all documentation (including but not limited to Iowa Ryan White Part B Applications, AIDS Drug Assistance Program applications, financial documentation, supporting documents, etc.) from the past two years. If a client has not been enrolled with a Ryan White Provider for more than two years, the file cannot be archived.

Archived files require the same amount of security as current client files do. Archived client files must be kept in a confidential, secure, and locked space with access limited only to the case manager, the case manager's supervisor, and any other program staff. The IDPH may access client files at any time.

8.4 Required Forms

The Iowa Department of Public Health (IDPH) along with the Community Planning Group (CPG) developed a standardized set of forms that all Part B providers are required to use. Below is a list of the required forms, the purpose of the form, when the form should be used, and the program/s that form is required for. As you read through the standards and guidelines for the core and support services (in sections 3.0 and 4.0 respectively) the forms will also be listed as "required documentation" when required.

All forms can be found as appendixes in this document. ADAP specific forms can be found in the ADAP manual.

Form Name	Form Purpose	When used	Program/s required for
Iowa Ryan White Part B Application	This form has multiple purposes: - A comprehensive biopsychosocial assessment (Iowa Standard Intake/Assessment) - ADAP application -Acuity Scale.	Based on the level of Case Management the client is enrolled in.	Portions of the application are required for: - Medical Case Management - Non-Medical Case Management - Brief Contact Management - ADAP
Clients Rights, Responsibilities, and Grievance Procedure	Used to give client's a clear understanding of what their rights are as a Ryan White client, what their responsibilities are, and how to file a grievance.	Signed annually	- All levels of Case Management - ADAP

Iowa Client Care Plan (3 form options)	Used to document goals developed and progress made by the CM and CL based on the needs identified.	Completed annually, follow up done bi-annually	- Medical Case Management - Non-Medical Case Management - Brief Contact Management (Optional)
Case Management Enrollment and Client Consent Form	Provides a description of case management and services. A signature on this form will allow for CD4 & viral load data to be shared with case manager via CAREWare (valid one year). Client must sign this form in order to participate in case management services.	Signed upon enrollment	- All levels of Case Management
Consent to Release of Confidential Information	This release is valid for a two-week period (e.g., use for one time release of medical records)	Signed as needed	Not required, but can be useful for one time release of information.
Consent to Exchange Confidential Information	This release is valid for one year from the date of signature. Must have at least one release to HIV medical provider.	Signed annually as needed	- Medical Case Management - Non-Medical Case Management - Brief Contact Management
Ryan White Part B Case Management Discharge Summary	Used to document and summarize a client's discharge from case management services, including discharge reason, date, and a summary of services provided.	Completed as needed when client discharged from case management.	- All levels of Case Management
ADAP Coversheet	Used as a coversheet to the ADAP application. Communicates to the ADAP office which program the client is applying for, a summary of the client's situation, and a summary of the clients need for ADAP.	Submitted with annual ADAP re-enrollment and six-month re-certification	- ADAP
Enrollment Agreement for the ADAP	Provides a description of ADAP. Client must initial all 8 lines specified and sign this	Signed annually at re-enrollment	- ADAP

	form in order to be enrolled in ADAP.		
ADAP Income Worksheet	Fillable form used to calculate client income for ADAP.	Completed at annual re-enrollment and six-month re-certification	- ADAP
Iowa ADAP Client Insurance Information	Communicates to the ADAP office client's insurance information.	Completed at annual re-enrollment and six month re-certification	- ADAP (Insurance Assistance Program- NON-ADAP sponsored Insurance ONLY)
Six Month ADAP Recertification Form	Used to complete ADAP six-month recertification. Provides information needed to ensure client remains eligible for ADAP.	At six month re-certification	- ADAP
ADAP Exception to Policy Form	Communicate to and request approval from the ADAP office regarding client's extenuating circumstances that may affect their participation in ADAP.	As needed	Only required if an exception to ADAP policies/procedures is needed
ADAP Transfer Summary	Used when a client enrolled in ADAP is transferring from one case management agency to another within Iowa.	As needed.	- ADAP
ADAP Discharge Summary	Used to discharge clients from ADAP.	As needed.	- ADAP

9.0 Policy and Procedure Requirements

Each Ryan White Part B Provider must establish written policies and procedures specific to each of the services they provide. In addition, general agency operation policies must be established and documented. The Policies and Procedures Manual should be reviewed on an annual basis and updated as indicated.

9.1 Definitions

Standard: an established norm or requirement. It is usually a formal document that establishes uniform, criteria, methods, processes, and practices.

Policy: a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental body.

> *Interpretation:* A policy outlines the general practice for a particular area of service that will direct how an agency will meet the established standard. Policies should be established at a minimum for each service area and for general agency activities that contribute to the successful provision of service.

Procedure: a specified series of actions, acts, or operations which have to be executed in the same manner in order to consistently obtain the same result under typical circumstances. To a lesser extent, this term can indicate a sequence of activities, tasks, steps, decisions, calculations and processes that when undertaken in the sequence indicated produces the described result, product, or outcome.

> *Interpretation:* Procedures should exist for each policy that directs staff members on how to specifically complete a task in order to establish a standardized and equitable level of service for clients.

9.2 Minimum Requirements for Establishing Policies & Procedures

All policies and procedures should be reviewed, updated, and approved on an annual basis (at a minimum). These dates, as well as the original effective date, should be on the written policy along with the supervisory staff position responsible for monitoring compliance with the policy. Each of the policies should include a description of appropriate documentation, eligibility criteria for recipients and limitations or established caps on services (if applicable).

9.2.1 Administrative Policies and Procedures

This section includes a list of policy and procedure areas that satisfy the minimum requirement. For each of the areas, a description and instructions are provided.

Description: a brief explanation of what the policy should outline.

Instructions: guidelines for drafting the policy and procedures and what needs to be included.

Service Eligibility and Enrollment Procedures

Description: Eligibility requirements and enrollment procedures for case management and all other services.

Instructions: Written policies and procedures for *Services Eligibility and Enrollment Procedures* should cover:

- How to determine program eligibility:
    - Requirements
        - HIV status
        - HIV disease stage
        - Demographics, such as – but not limited to:
            - Residency
            - Age
            - Income
    - Eligibility screening:
        - Process
        - Required documentation
        - Forms
        - Responsible staff
    - Wait-list protocol
- How to complete a client intake:
    - Timeframe for completion of client intake
    - Responsible staff
    - Required documentation
    - Provision of interpretation/translation services to non-English speaking clients
    - Client assignment
        - Process for assigning clients to case manager
        - Responsible staff
        - Time frame

Crisis Intervention

Description: Protocol for addressing client crisis during business, as well as nonworking hours, as it relates to mental health, substance abuse, or other emergency issues.

Instructions: Written policies and procedures for *Crisis Intervention* should cover:

- Dealing with suicidal/homicidal clients, including assessment and referral
- Handling workplace violence, including notification of responsible parties in case of emergent situations
- Plan for staff training and development regarding crisis intervention strategies
- Staffing to cover non-working hours to ensure availability for client crisis interventions

    'Staffing' can include ensuring that contact information for referrals for mental health crises, medical emergencies, etc. is available on agency voicemail.

Documentation

Description: Procedures for establishing client records and recording on-going activities.

Instructions: Written policies and procedures for Documentation should cover:

- Client record format, order, retention, security, and proper disposal
- Supervisory review of client records.

Client Confidentiality

Description: Protocol for maintaining client confidentiality.

Instructions: Written policies and procedures for *Client Confidentiality* should cover:

- Disclosure of client information
    - Voluntary
    - Involuntary (mandatory reporting)
- Release of information
    - Consent to release
    - Consent to exchange
- Breach of confidentiality
    - Definition of "breach"
    - Reporting
        - Responsible staff
        - Protocol
        - Required documentation/forms

    - Notification
        - Client
        - IDPH
    - Investigation
        - Responsible staff
        - Time frame (from incident report date)
        - Action steps
- Agency safeguards
    - Record security
    - Record storage
    - Record disposal
- Client privacy
    - Waiting room/ lobby
    - Meeting spaces
    - Communications and correspondence, such as:
        - Caller ID
        - Return addresses on envelopes
        - Voicemails

Client Input and Satisfaction

Description: Process for soliciting client views and feedback on current and planned program services including activities such as a Client Advisory Board, focus groups, and client satisfaction surveys.

Instructions: Written policies and procedures for *Client Input and Satisfaction* should cover:

- Agency activities to obtain client input
    - Time frame and frequency of activities
- Agency activities to review and utilize client input
    - Time frame and frequency of activities

Data/Reporting

Description: Procedure for entering data into electronic records for the purposes of consistency of care, movements towards goals, internal tracking, and state/federal required reporting.

Instructions: Written policies and procedures for *Data/Reporting* should cover:

- Data entry detailing:
    - Person(s) responsible for entering data

- Frequency and timeframe for data entry
- The process for internal review of data
- Process for reporting data to the state and federal government (if applicable)

Quality Management (Quality Assurance and Quality Improvement)

Description: Process agency will use for measuring quality of case management and other services to make improvements to the quality of services provided.

Instructions: Written policies and procedures for *Quality Management,* including *Quality Assurance and Quality Improvement*, should cover the basic elements found below, but may be less comprehensive given the current state of development.

- Quality Management Program structure
  - Quality statement
  - Annual quality goals
    - Based on data
  - Description of the quality management plan activities and oversight
    - Quality assurance overview
      - Responsible staff
      - Required documentation
      - Reviews
        - Random
        - Peer
        - Administrative
      - Review of results
    - Quality improvement overview
      - Responsible staff
      - Required documentation
      - Client involvement
      - Development and measurement of key indicators
      - Review of results
      - Execution
    - Quality management work plan
      - Table of quality management (quality assurance and quality improvement) activities
        - Activities
        - Responsible staff

        - Frequency
        - Timeframe
        - Completion status
    - Participation of stakeholders (agency)
        - Internal
        - External
        - Clients
    - Evaluation
        - Responsible parties and assigned roles/tasks
        - Required documentation
        - Schedule and/or timeframes
            - Reviews

Staff Qualifications

Description: Description of qualifications necessary for all case management positions.

Instructions: Written policies and procedures for *Staff Qualifications* indicate what criteria should be in place for each member of the case management staff.

- Written Job descriptions
    - Qualifications included in job description
    - Skills, traits, and/or attitudes
        - Communication and interpersonal skills
        - Creativity, flexibility, and accountability
        - Time management skills
        - The ability to develop a rapport
        - An emphasis and understanding of professionalism, ethics, and values
        - Ability to use a strengths based perspective when working with clients
        - Utilization of a holistic approach
        - Ability to establish and maintain appropriate boundaries
    - Education
        - *Preferred:* a degree in health, human, or education services and one year of case management experience

Staffing Structure

Description: Staffing plan for the delivery of case management and other services.

Instructions: Written policies and procedures for *Staffing Structure* indicate tiers of case management to be delivered, individual or team approach to staffing and line(s) of supervision.

- Written case management program plan
    - Case management tiers delivered
    - Other services delivered
    - Organizational chart
    - Job descriptions

Staff Supervision

Description: Description of on-going supervision of case management staff and their activities.

Instructions: Written policies and procedures for *Staff Supervision* should cover:

- Staff positions responsible for supervision
- Type and frequency of supervisory activities, including:
    - Case reviews with case management staff
    - Staff job performance
- Necessary documentation, including:
    - Necessary forms
    - Location of documentation
    - Steps taken to ensure confidentiality for staff information.

Staff Training

Description: description of how staff will be trained, including orientation, required topics, and frequency of training.

Instructions: Written policies and procedures for *Staff Training* should cover:

- Written orientation curriculum
- Mandatory training for case management staff indicated by governing body, funder, agency administration, and/or best practices*
- Case manager certification and continuing education, as required by the Iowa Department of Public Health (IDPH)
- Staff training records must be maintained by supervisors and are subject to review by the IDPH.

* Any mandatory training should include, but is not limited to, those which increase provider knowledge and proficiencies in such a way as to enhance and increase the efficacy of provided case management services (e.g. confidentiality, cultural competency, Motivational Interviewing, mental health/substance abuse issues, ethics, etc.).

Corrective Measures

Description: Description of agency response to the mismanagement of professional responsibilities by staff members.

Instructions: Written policies and procedures for *Corrective Measures* should cover:

- Process for identifying incidents that require corrective measures
- Description of how any mismanagement of professional responsibilities by staff members will be handled by supervisory staff, including:
    - Examples of job infractions which necessitate corrective measures
    - Levels of correction
    - Documentation utilized to record corrective measures
    - Clear identification of the department(s) authorized to access said documentation at any given level of corrective measures.

9.2.2 Service Area Policies and Procedures

This section includes a list of policy and procedure areas that satisfy the minimum requirement. For each of the areas, a description and instructions are provided.

> Description: a brief explanation of what the policy should outline.
>
> Instructions: guidelines for drafting the policy and procedures and what needs to be included.

Case Management

Description: Protocol for conducting case management activities as stated in the Iowa Case Management Standards of Care (Section 3.0).

Assessment/Reassessment and Acuity Level

Description: Protocol for conducting assessments, reassessments, and acuity level measurement including required documentation.

Instructions: Written policies and procedures for *Assessment/Reassessment and Acuity Level* should cover:

- A timeline for completion of initial assessment & acuity measurement, indicating frequency of subsequent assessments & acuity reviews
- Staff responsibilities

- Required documentation
- Reassessment process
- The client's role

Care Plan

Description: Protocol for developing care plan and care plan follow up.

Instructions: Written policies and procedures for *Care Plan* should cover:

- A timeline for completion of initial care plan, indicating frequency of subsequent reviews
- Staff responsibilities
- Required documentation
- Client role in the process

Case Conferencing with Medical Provider

Description: Process, documentation, and frequency of required conferencing with a medical case managed client's medical provider.

Instructions: Written policies and procedures for *Case Conferencing with Medical Provider* should cover:

- Written case conferencing process
- Requirements for ensuring that appropriate Release(s) of Information re in place for all parties involved
- Frequency of case conferencing
- Mandatory participants
- Required documentation

Caseload Management

Description: Criteria and process utilized in determining client case assignment, continuity, and/or transfer of care to assure optimal provision of client services.

Instructions: Written policies and procedures for *Caseload Management* should cover:

- Caseload management
    - Responsible staff
    - Methods

    - Tools
    - Required documentation
- Case reviews
- Continuity/Transfer of care
    - Change in case manager
    - Client relocation

Client Contacts

Description: The minimum expected type and frequency of case management contacts with clients as indicated by client acuity and/or presenting issues.

Instructions: Written policies and procedures for *Client Contacts* should cover:

- A case manager/client contact schedule
    - Initial cm contact (post-intake)
    - Contact requirements by acuity (minimum)
        - Face to face
        - Phone
    - Exceptions (presenting issue(s) vs. acuity scale)
- Outline the process for documenting and tracking these contracts
    - Tools
    - Required documentation

Referrals and Follow up

Description: Process for making, monitoring, and following up on client referrals to other providers (including intra-agency) and services.

Instructions: Written policies and procedures for *Referrals and Follow up* should cover:

- Tracking of active referrals including:
    - An outline of the process for making active referrals and subsequent follow-up
    - Required documentation
- An outline of the process for making passive referrals
- Updating (at least annually) a current list of primary agencies that provide appropriate referral services (e.g. food pantry, housing, mental health).
- Establishing Memoranda of Understanding (MOU) with provider networks to meet client needs.

Case Closure and Case Transition

Description: Protocol for the closure or transfer of case management cases, including criteria for transfer, closure, closure process, and required documentation.

Instructions: Written policies and procedures for *Case Closure and Case Transition* should cover:

- Transferring a client's case management record to another provider (internal or external), including:
    - Outline the timeframe and process for transitions
    - Necessary documentation
    - Guidance on indicators for appropriateness of transfer
    - Staff communication expectations.
- Case closure
    - Outline the timeframe and process for case closures
    - Necessary documentation
    - Guidance on indicators of appropriateness of case closure
    - Staff communication expectations.

Other Support Services

Description: Protocol for approving and distributing support services assistance, such as (but not limited to):

- Medical Transportation
- Oral Health Care
- Mental Health Services
- Food Bank
- Support Groups
- Health Insurance Premium & Cost-Sharing Assistance
- Substance Abuse Services
- Emergency Financial Assistance

Instructions: Outline the process for documenting and tracking services and/or deliverables, as well as client eligibility criteria for clients and staff responsible for approval, service delivery, and management.

Appendix A

Ryan White Part B Core and Support Services

Ryan White Core and Support Services

Core Services:

Outpatient/Ambulatory Medical Care (Health Services) 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. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and screening of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

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.

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or B Grantees to provide HIV medication to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

Oral Health Care includes diagnostic, preventative, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Early Intervention Services (EIS) include counseling individuals with respect to HIV; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV; periodic medical evaluations for individuals with HIV; and providing therapeutic measures.

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.

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

Home and Community-based Health Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate metal health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **not** included.

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

Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

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 provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical Case Management Services 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 treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic 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 including face to face, phone contacts, and any other forms of communication.

Substance Abuse Services Outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e. alcohol, and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Support Services:

Case Management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

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 Program related meetings, groups, or trainings.

Pediatric Developmental Assessment and Early Intervention Services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

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, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Food Bank/Home-Delivered Meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health Education/Risk Reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

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

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 Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistic Services include the provision of interpretation and translation services.

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

Outreach Services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e. case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. 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 epidemiological data to be disproportionate risk for HIV infection; be conducted at times and in places where there is high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency Planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or no longer able to care for them.

Psychosocial 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 dietitian but excludes the provision of nutritional supplements.

Referral for Health Care/Supportive Services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made with the non-medical case management system by professional case manager, informally through support staff, or as part of an outreach program.

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

Respite Care is the provision of community or home-based, non-medical assistance designed to relieve the primary care giver responsibility for providing day-to-day care of a client with HIV.

Substance Abuse Services – Residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Treatment Adherence Counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV treatments by non-medical personnel outside of the medical case management and clinical setting.

Appendix B

Ryan White Part B Provider List

Cedar AIDS Support System
P.O. Box 2880
Waterloo, Iowa 50704
P: 319-272-2437

Dubuque Visiting Nurses Association
1454 Iowa Street
Dubuque, Iowa 52001
P: 563-556-6200

Linn County Community Services
1240 26th Avenue court SW
Cedar Rapids, Iowa 52404
P: 319-892-5770

Mid-Iowa Community Action Agency
230 S.E. 16th Street
Ames, Iowa 50010
P: 515-956-3333

Nebraska AIDS Project
250 South 77th Street, Suite A
Omaha, Nebraska 68114
P: 402-552-9260

North Iowa Community Action Organization
100 1st Street NW, Suite 200
Mason City, Iowa 50401
P: 641-423-5044

Siouxland Community Health Center
1021 Nebraska Street
P.O. Box 5410
Sioux City, Iowa 51102
P: 712-252-2477

The Project at Primary Health Care
1200 University Ave, Suite 120
Des Moines, Iowa 50314

The Project Quad Cities
P.O. Box 3306
Davenport, Iowa 52808
P: 319-892-5770

University of Iowa Health Care
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-384-7307

Appendix C

Ryan White Part C Provider List

Ryan White part C Provider List

Genesis Health Group Infectious Disease
500 West River Drive
Des Moines, Iowa 52801
P: 563-336-3186

Siouxland Community Health Center
1021 Nebraska Street
P.O. Box 5410
Sioux City, Iowa 51102
P: 712-252-2477

The Project at Primary Health Care
1200 University Ave, Suite 120
Des Moines, Iowa 50314

University of Iowa Health Care
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-384-7307

Appendix D

HOPWA Provider List

HOPWA Provider List

Cedar AIDS Support System
P.O. Box 2880
Waterloo, Iowa 50704
P: 319-272-2437

Nebraska AIDS Project
250 South 77th Street, Suite A
Omaha, Nebraska 68114
P: 402-552-9260

Siouxland Community Health Center
1021 Nebraska Street
P.O. Box 5410
Sioux City, Iowa 51102

The Project at Primary Health Care
1200 University Ave, Suite 120
Des Moines, Iowa 50314

The Project Quad Cities
P.O. Box 3306
Davenport, Iowa 52808
P: 319-892-5770

University of Iowa Health Care
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-384-7307

Appendix E

Part B Application

Iowa Ryan White Part B Application

This form serves multiple purposes in the Iowa Ryan White Part B program. Please review the following uses of this form and complete the appropriate pages. Submit documentation where requested.

Applicant Information		
Name:		
Last	First	MI
Social Security Number	Birth date	

Brief Intake: To complete the Brief Intake as outlined in the standards, complete the below Initial Client Contact section and pages 1 -2, or gather as much information as possible during your initial contact with client.

Initial Client Contact	
Date of Initial Client Contact:	Referral Source:

AIDS Drug Assistance Program (ADAP) Application: To complete the ADAP application as outlined in the ADAP manual, complete the below ADAP Application Information section and pages 1-8. **The ADAP application must be submitted to IDPH to enroll or re-enroll in ADAP.**

ADAP Application Information		
Date of ADAP Application:	Completion Date:	Date of 6 Month Recert:
ADAP ID#:	Check One: ☐ New ☐ Renewal ☐ Returning Client (previously discharged)	

Iowa Standard Assessment: To complete the Iowa Standard Assessment as outlined in the standards, complete the below Iowa Standard Assessment Information section and pages 1-14.

Iowa Standard Assessment Information		
Date of Annual Assessment:	Completion Date:	Required Contact: ☐ Monthly ☐ 3 Month ☐ 6 Month ☐ Annually
Client #:	Check One: ☐ New ☐ Reopen ☐ Re-assessment ☐ Transfer from _____	

Iowa Acuity Scale: To complete the Iowa Acuity Scale as outlined in the standards, complete the Contact Information section on page 1 and all of page 14.

Contact Information

Phone and Email: Please describe any concerns you may have with staff contacting or leaving messages at the below numbers and addresses.

Home: ☐ Discretion	Cell: ☐ Discretion	Email Address: ☐ Discretion
List concerns / limitations:		

Residential Address (where you live)

Street:	City:	State:	Zip:	County:
May we contact you at this address? ☐ Yes ☐ No Discretion? ☐				

Mailing Address Check here if same as residential address ☐

Street:	City:	State:	Zip:	County:
May we contact you at this address? ☐ Yes ☐ No Discretion? ☐				

Demographic Information

Gender			**Sex at Birth**	
☐ Male	☐ Female	Transgender ☐ M to F ☐ F to M	☐ Male	☐ Female

Ethnicity

☐ Hispanic
Subgroup:
☐ Mexican, Mexican American, Chicano/a ☐ Cuban
☐ Puerto Rican ☐ Another Hispanic, Latino/a, or Spanish Origin

☐ Non-Hispanic

☐ Prefer not to answer

Race

☐ White	☐ Black or African American	☐ Multi-racial
☐ Asian Subgroup: ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese ☐ Other Asian	☐ American Indian/Alaska Native	☐ Other/Prefer not to answer
	☐ Native Hawaiian/Other Pacific Islander Subgroup: ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro ☐ Other Pacific Islander	

First Language

☐ English	☐ Spanish	☐ Other, Specify:	If English is NOT the primary language, how will you communicate with client?

Citizen Status

☐ US Citizen	☐ Visa	☐ Refugee	☐ Permanent Resident	Country of Origin:

Initial Information (Only complete during Brief Intake)

HIV Doctor/Clinic:	Doctors Phone:
Currently on HIV medications: ☐ Yes ☐ No	Immediate Medication Need: ☐ Yes ☐ No
Employed: ☐ Yes ☐ No	Employer:
Insurance provider:	

Benefits:

☐ Food Stamps	☐ Medicaid	☐ Medicare
☐ SSI / SSDI	☐ Child Support	☐ Section 8
☐ Pension/Retirement	☐ Unemployment	☐ VA
☐ Other:	☐ Other:	☐ Other:

INITIAL NEEDS IDENTIFIED (Only complete during Brief Intake)

- ☐ Case Management
- ☐ Client advocacy, information, and referral
- ☐ Medical Care
  - ☐ HIV Specialist
  - ☐ Dentist
  - ☐ Other
- ☐ Medication Access
  - ☐ ADAP
  - ☐ Patient Assistance Program
- ☐ Medication Adherence
- ☐ Benefits Counseling
- ☐ Substance Use/Addiction Evaluation/Treatment
- ☐ Mental Health Evaluation/Treatment
- ☐ Domestic Violence
- ☐ HIV disease information/education
- ☐ Counseling/Therapy
- ☐ Housing
- ☐ Transportation
- ☐ Food Pantry
- ☐ Financial Assistance/counseling
- ☐ Representative payee
- ☐ Support Groups
- ☐ Prevention/Risk Reduction Supplies
- ☐ CTR for sex/needle sharing partners
- ☐ Employment Services
- ☐ Legal Services/Advanced Directives
- ☐ GED/ continuing education
- ☐ ESL (English as 2nd language)
- ☐ Child Care/Dependents/Parenting skills, etc.
- ☐ Vocational Rehab
- ☐ Home Health
- ☐ Hospice
- ☐ Durable Medical Equipment
- ☐ Skilled Nursing Facility/Intermediate Care Facility

Notes/Initial Referrals (Only complete during Brief Intake)

_____

_____

_____

_____

_____

Emergency Contact Aware of HIV Status? Yes ☐ No ☐			
Relationship to Client:	Signed Release in file? Yes ☐ No ☐		
Name:	Phone Number and/or Email Address:		
Street Address:	City:	State:	Zip:

Household & Employment Information

List every person who lives with you. If they are included in your taxable household unit select "yes" under Count toward ADAP. See ADAP manual for additional guidance. Attach additional sheets if needed.

Full Name	Relationship	Gender	DOB (minors)	Aware of HIV Status?	Count toward ADAP?
	APPLICANT			☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No

Do you have dependent children who do not live with you? ☐ Yes ☐ No Number: _____
Are any other household members living with HIV? ☐Yes ☐No If yes, who? _____

Marital Status (including same-sex marriage)		
☐ Single	☐ Married Same Sex Marriage? ☐Yes ☐No	☐ Divorced
☐ Widowed	☐ Separated	☐ Other, specify:

Women Only	
Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know	If you are pregnant, what is your estimated delivery date?
Are you breastfeeding? ☐ Yes ☐ No	Are you on birth control? ☐ Yes ☐ No

Client's Employment Status				
☐ Full time ___hours per week	☐ Part Time ____hours per week	☐Seasonal/ temporary	☐ Self employed	☐ Retired
Name of employer(s), if employed, and job title(s):				
☐ Unemployed: If unemployed, when and where were you last employed?				

Spouse's Employment Status				
☐ Full time _____hours per week	☐ Part Time _____hours per week	☐ Seasonal/ temporary	☐ Self employed	☐ Retired
Name of employer(s), if employed, and job title(s):				
☐ Unemployed: If unemployed, when and where was your spouse last employed?				

Income Information

Describe the monthly gross income that each person brings to the household. Documentation must be provided for each income area.

Sources of Income/Benefits	**Applicant**	**Spouse**	**Other Household Members**	**Required Documentation**
Wages, salary, commissions, tips				The most recent paystubs for at least a full thirty days of consecutive income with **the current paystubs gross income amounts circled**, or a signed employer statement with dates worked, position, salary, and contact information.
Self employment income				A completed copy of your most recent Federal Income Tax Return.
Interest, cash dividends or investment income				
Unemployment Benefits/Income				A copy of your benefit award letter or any other official documentation showing the pay period (i.e. weekly, bi-monthly, etc.) and the amount received on a regular basis.
Social Security Income (retirement or disability benefits) Effective Date: _____				
Retirement Pension Benefits				
Veteran's Benefits				
Supplemental Security Income				
Other Disability Benefits/Income				
Alimony/child support received				
Other Income (specify source)				
No Income				A No Income Verification Form must be submitted for each person claiming zero income.
MONTHLY TOTAL:				**TOTAL ANNUAL INCOME:**

MAGI Calculation (For ADAP Only)

Modified Adjusted Gross Income (MAGI)	**Required Documentation**
	A completed copy of your most recent Federal Income Tax Return; most recent paystub with Year-to-Date income and pay date circled; completed, signed, and dated MAGI Worksheet.

Do you receive food assistance? ☐ No ☐ Yes If yes, list monthly amount $_____ Name of Program:_____

Do you have access to basic needs (food & clothing)? ☐ Yes ☐ No

Do you have a payee? ☐ No ☐ Yes If yes, list name/phone: _____

Do you have debt? ☐ No ☐ Yes If yes, explain what kind and how much: _____

Is your income sufficient to meet your monthly financial obligations/basic needs? ☐ Yes ☐ No

Comments regarding income: _____

Health Insurance Information

Please attach a copy of your health insurance card and prescription drug card for any programs in which you are enrolled.

Do you receive Medicaid? ☐ Yes ☐ No

If yes, please specify the program are you covered under:	**If no, explain:**
☐ Title 19 (full Medicaid)	☐ Application is pending, list date applied: _____
☐ Med Needy: spend down amount $_____	
☐ MEPD: premium amount $_____	☐ Application was denied, list date applied: _____
☐ Medicaid for Families & Children	
☐ QMB/SLMB	☐ I am ineligible, list reason: _____
☐ Iowa Health and Wellness	
☐ Iowa Health and Wellness Marketplace Choice Option	☐ I have not applied, list reason: _____
☐ Health Insurance Premium Payment (HIPP)	

Do you receive Medicare? ☐ **Yes (Check all that apply)**** ☐ **No**

☐ Covered under Part A (inpatient)	☐ Covered under Part B (outpatient)	☐ Covered under Part D (prescription plan)**	☐ I'm eligible for Medicare but use private insurance instead

Medicare #: _____ Effective Date: _____

**** If applying for ADAP, please complete ADAP Client Insurance Form for all Part D plans.**

Are you covered under Private Health Insurance? ☐ **Yes (Check all that apply)**** ☐ **No**		
☐ I am covered under a plan through my employer	☐ I am covered under a plan through a retirement plan	☐ I have an individual health insurance policy
☐ I am covered under a plan through the Marketplace	☐ I am covered or eligible for insurance under someone else's policy	☐ I am covered under COBRA which expires on ___/____/____
Are you eligible for employer sponsored insurance? ☐ **Yes** ☐ **No**		
☐ I am unsure if I am eligible for or covered by private health insurance	☐ My employer offers health insurance, but I did not elect. List open enrollment period dates _____	
If you are eligible for private health insurance, but not currently covered, explain why:		
If you are covered under private health insurance, provide the following information: Do you have dental coverage? ☐ Yes ☐ No Do you have vision coverage? ☐ Yes ☐ No **** If applying for ADAP, please complete ADAP Client Insurance Form for all private or marketplace insurance plans.**		

Please note any other health coverage programs from which you receive benefits:

☐ Veterans Benefits ☐ HAWK-I (for children) ☐ Co-Pay Assistance Cards ☐ Pharmaceutical Assistance Program

Health Status

HIV Clinical Information

☐ **AIDS diagnosis** ☐ **HIV + (not AIDS)** ☐ **HIV+ (AIDS status unknown)**

HIV diagnostic date: _____ State residing when diagnosed with HIV: _____

AIDS diagnostic date:_____ State residing when diagnosed with AIDS: _____

Most recent CD4 Count:	Date	Most recent Viral Load:	Date

HIV Risk Factors for Infection:

☐ Male who has sex with male(s) ☐ Heterosexual Contact
☐ Hemophilia/coagulation disorder ☐ Perinatal transmission
☐ Injecting Drug Use ☐ Receipt of blood transfusion, blood components, or tissue
☐ Other, specify:

HIV Specialist: Does client receive assistance from Ryan White part C? ☐**Yes** ☐**No**

_____	_____	_____
Doctor Name	Provider Clinic	Provider Telephone #

When were you last seen by an HIV specialist? _____
When is your next appointment with an HIV specialist? _____

How often are you regularly seen by an HIV specialist? _____

What is your understanding of the importance of regular medical care? ☐ Thorough ☐ Basic ☐ Limited

What is your understanding of CD4/viral load significance: ☐ Thorough ☐ Basic ☐ Limited

Drug Adherence

Are you currently taking HIV medications? ☐ Yes ☐ No

If yes, please list all medications and dosages:

HIV medication name	# of pills/dosage per day/time of day

If no, please specify reason:

☐ Not recommended by provider at this time. Please explain:

☐ Does not want to take HIV medications. Please explain:

What is your routine for taking your medications?

How many pills did you miss taking last week?

How many doses did you take late last week?

On average, how many days per week do you miss at least one dose of your HIV medications? _____

If client missed any doses, what were the reasons?

Calculate client's % of adherence: Total doses taken/total doses prescribed x 100 = _____ % adherence

List **all** pharmacies that you use:

Name: _____ Name: _____ Name: _____

Phone: _____ Phone: _____ Phone: _____

Do you ever run out of pills before you get your next refill? ☐ Yes ☐ No

What is your understanding of how your medication works? ☐ Thorough ☐ Basic ☐ Limited

Have you ever stopped taking meds without the doctor's permission/knowledge? ☐ Yes ☐ No ☐ N/A

Is medical provider aware of adherence problems? ☐ Yes ☐ No ☐ N/A

Do you use complementary therapies? ☐ No ☐ Yes Is medical provider aware? ☐ Yes ☐ No ☐ NA

If yes, describe:

Do you experience any side effects? Specify: _____

Do you take medication for side effects? Specify: _____

What medications do you take other than HIV meds?	
Medication name	# of pills/dosage per day/time of day

Barriers to Medication Adherence: _____

_____

_____

ADAP Supporting Documents

Proof of Iowa Residency (Check here if documentation is attached ☐) **Only one document is needed**		
☐ Utility bill in your name with Iowa service address (gas, electric, cable, water, phone, etc.) **(Current within last 3 months)**	☐ Rent Receipts (Iowa address must be printed on the receipt) **(Current within last 3 months)**	☐ Lease with Iowa address **(Current within the last 12 months)**
☐ Letter addressed to your name with a valid postmark **(Current within last 3 months)**	☐ Signed letter from case manager / social worker (homeless or transitional housing) **(Current within last 3 months)**	☐ Mortgage statement with Iowa address **(Current within the last 3 months)**
☐ Other (describe):		
Proof of Income (Check here if documentation is attached ☐) Check all that apply		
☐ Pay Stubs (4 weeks worth)	☐ SSDI/SSI Statement	☐ Taxes
☐ Unemployment Statement	☐ No Income statement	☐ Letter from employer
☐ Other (describe):		
Insurance Card (Check here if documentation is attached ☐)		
☐ Employer Sponsored Insurance	☐ Medicaid	☐ Medicare
☐ Private Insurance	☐ Marketplace Insurance	☐ Other (describe):

THIS ENDS THE ADAP APPLICATION

General Medical

Where do you usually seek medical care (non-HIV related)? _____

Who is your primary health care provider (non-HIV related)? _____

Please list and describe other medical conditions: _____

_____

_____

_____

Describe general health and wellness (exercise, self care, hygiene, nutrition, etc.): _____

_____

_____

Dental

Do you receive dental care? ☐ Yes ☐ No

If no, do you understand the importance of regular dental care? ☐ Yes ☐ No

If yes, where? _____

Do you get your six-month checkup? ☐ Yes ☐ No Date of last visit? _____

Do your teeth or dentures inhibit you from eating? ☐ Yes ☐ No

If yes how? _____

Housing

Current Housing Situation:

- ☐ **Stable/Permanent**
- ☐ **Non-Permanently Housed**
- ☐ **Institution**
- ☐ **Unknown/Unreported**
- ☐ **Unstable**
- ☐ **Other** (Please Specify): _____

Rent/Mortgage $ _____ Utilities $ _____

Have you accessed utility assistance/LIHEAP? ☐ Yes ☐ No

Are you behind on rent and/or utilities? ☐ Yes ☐ No If yes, explain: _____

Do you receive a subsidy? ☐ Yes ☐ No

If yes, name of program: _____

Are you in danger of being evicted? ☐ Yes ☐ No If yes, date of eviction: _____

Specify: _____

_____

Other comments regarding housing:

_____

_____

Education

Highest grade you completed in school? _____

Are you currently enrolled in college courses or a GED program? ☐ Yes ☐ No

If yes, where are you currently enrolled? _____ Number of hours/credits: _____

List any degrees/certificates earned (GED/AA/BA/vocational training, etc.) _____

Do you have difficulty reading? ☐ Yes ☐ No

Do you have difficulty writing? ☐ Yes ☐ No

Developmental Disability/Cognitive Impairment? ☐ Yes ☐ No If yes, specify: _____

If yes, are services in place ☐ Yes ☐ No ☐ NA If yes, what services? _____

Transportation

Do you have access to and funds for transportation (car, gas, bus pass, etc)? ☐ Yes ☐ No

Do you need help arranging transportation (Paratransit, volunteer, etc)? ☐ Yes ☐ No

Has limited access to transportation ever kept you from attending a medical appointment? ☐ Yes ☐ No

Barriers/Comments: _____

_____

Advance Directives

Do you have any of the following? (Check all that apply) ☐ **None**			
☐ Financial Power of Attorney	☐ Will (personal & property)	☐ Guardian/Conservator	☐ Living Will
☐ Power of Attorney for Healthcare Who is your power of attorney for healthcare, if applicable? _____			

Would you like information on advance directives at this time? ☐ Yes ☐ No

Legal

Are you currently involved in a civil/criminal legal matter? ☐ Yes ☐ No If yes, describe: _____

_____

Do you have a history of arrests? ☐ Yes ☐ No

Have you ever been in jail or in prison? ☐ Yes ☐ No If yes, when and what were the charges? _____

_____

Are you currently on probation/parole? ☐ Yes ☐ No If yes who is your probation/parole officer? _____

Are you aware of Iowa's HIV transmission law? ☐ Yes ☐ No

Prevention Needs/HIV Knowledge/Risk Reduction Strategies

Are you currently sexually active? ☐ Yes ☐ No If yes, risk reduction strategies used:

Barriers to discussing/practicing safe behaviors:

What is your understanding of HIV transmission risks? ☐ Thorough ☐ Basic ☐ Limited

Do you disclose your HIV status to your sexual partners? ☐ Yes ☐ No

If not currently engaging in sex with partners, do you have a plan to keep you and your partner safe if you were to become sexually active? Please describe:

_____

_____

Do you have access to condoms and other safe sex/risk reduction supplies? ☐ Yes ☐ No

Is there anything about safer sex practices or sexual risk that you want to know more about? ☐ Yes ☐ No

If yes, what? _____

Substance Use/Addiction

☐ No Drug/Alcohol History

Are you currently receiving drug/alcohol treatment? ☐ Yes ☐ No ☐ Not applicable

Program	Phone	Counselor/Therapist	Frequency of Visits	Length of Time in Program

Have you ever received drug/alcohol treatment? ☐ Yes ☐ No ☐ Not applicable

If applicable: (place an asterisk * next to the drug of choice)

Drug Used	Duration (years)	Frequency of Use	Date of Last Use	Mode (e.g. IDU)

If you inject drugs, do you share your needles or syringes? ☐ Yes ☐ No

Do you know how to clean your works? ☐ Yes ☐ No

Do you identify drugs as a problem? ☐ Yes ☐ No

Do you identify alcohol as a problem? ☐ Yes ☐ No

Does significant other or family identify drugs/alcohol as a problem for you? ☐ Yes ☐ No

Is gambling a problem for you now or are you experiencing financial difficulty due to gambling? ☐ Yes ☐ No

Does significant other or family identify gambling as a problem for you? ☐ Yes ☐ No

Comments:

_____

_____

Support System

Please describe your current support network? Do you feel it is adequate?

_____

_____

Barriers:

_____

_____

Domestic Violence

Have you ever felt afraid of your partner or ex-partner? ☐ Yes ☐ No

Has *a partner or ex-partner currently or ever:*

Pushed, grabbed, slapped, choked or kicked you?	☐ Yes ☐ No
Forced you to have sex or made you do sexual things you didn't want to?	☐ Yes ☐ No
Threatened to hurt you, your children or someone close to you?	☐ Yes ☐ No
Stalked, followed or monitored you?	☐ Yes ☐ No
Threatened to disclose your HIV status?	☐ Yes ☐ No
If yes to any of the above, was made referral to domestic violence/sexual assault agency? If yes, what agency? _____ If no, why? _____	☐ Yes ☐ No

Comments: _____

_____

Mental Health

Have you been diagnosed with any mental illness? ☐ Yes ☐ No If yes, what is your diagnosis?

☐ Anxiety ☐ Bipolar ☐ Depression ☐ Personality disorder ☐ Schizophrenia ☐ Other: _____

Have you ever been prescribed medication for a mental health diagnosis? ☐ Yes ☐ No

Are you currently receiving mental health treatment? ☐ Yes ☐ No ☐ Not applicable

Program	Phone	Counselor/Therapist	Frequency of Visits	Length of Time in Program

Have you ever received mental health treatment? ☐ Yes ☐ No ☐ Not applicable

If yes, explain the reason for treatment: _____

SUICIDAL IDEATION (Only ask if agency policy is in place)

Do you feel like hurting yourself? ☐ Yes ☐ No

If YES, do you have a plan? ☐ Yes ☐ No

If YES, what is your plan? _____

Have you ever hurt yourself? ☐ Yes ☐ No

If YES, describe what happened:

Date	Person/s Involved	Method	Reason

If client has been assessed at risk of suicide or homicide,
STOP and follow agency's Crisis Protocol.

Comments:

_____

_____

_____

Narrative Summary

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Applicant Information

Name:		
Last	First	MI

Acuity Scale

Review ALL levels of Case Management below, select boxes that best reflect client's current situation. Enroll client in appropriate level of case management.
If client is enrolled in ADAP, client must be enrolled in Level 1, 2, or 3 of Case Management.

Level 1: Medical Case Management (MCM)

- ☐ Newly Diagnosed (w/in 1 year)
- ☐ Viral Load > 200 copies/ml
- ☐ Not in HIV care
- ☐ Not on ARV's (if recommended)
- ☐ Medical emergency/hospitalization
- ☐ Not adherent to ARV's
- ☐ Not adherent to HIV medical appointments
- ☐ Other medical conditions not addressed(i.e. Hepatitis C, diabetes)
- ☐ Pregnant
- ☐ No access to ARV's

If 1 or more boxes are selected, consider enrolling client in MCM

Level 2: Non-Medical Case Management (Non- MCM)

- ☐ Isolation
- ☐ No insurance or Public Insurance (Medicaid, IHWP, etc.)
- ☐ Unstable housing
- ☐ Current domestic violence and/or abuse
- ☐ Post incarcerated re-entering
- ☐ Mental health needs (not being addressed)
- ☐ Financial needs identified (i.e. utility assistance, HOPWA, etc.)
- ☐ Current substance abuse
- ☐ Linguistic challenges
- ☐ Legal issues impeding other areas of life
- ☐ Transportation needs
- ☐ Income insufficient to meet needs
- ☐ Needs frequent assistance navigating the system
- ☐ No stable support network

If 1or more boxes are selected, consider enrolling client in Non-MCM

Level 3: Brief Contact Management (BCM)

- ☐ Moving from other HIV Case Management provider
- ☐ Adherent to ARV's
- ☐ Adherent to HIV medical appointments
- ☐ Stable housing
- ☐ Insurance (If client has Iowa Health and Wellness, it is highly recommended to enroll client in BCM, at a minimum)
- ☐ No current substance abuse
- ☐ Reliable access to transportation
- ☐ Steady source of income sufficient to meet needs
- ☐ Maintaining regular dental care
- ☐ Healthy, stable support network
- ☐ No mental health needs or needs being addressed

Level 4: Maintenance Outreach Support Services (MOSS)

☐ Meets all the criteria of BCM, has zero boxes selected in Level 1 or 2, and does **not** need AIDS Drug Assistance Program, consider enrolling in MOSS

Case Manager Notes/Exceptions to enroll client in level other than one identified:

_____

_____

_____

Final Level of Case Management ☐ MCM ☐ Non-MCM ☐ BCM ☐ MOSS	
Signature:	Date:

Appendix F

Narrative Reassessment Form

Narrative Reassessment Form

Client Name:

Client Contact Information
Phone:
Address:
E-mail:

Date of Intake:
Date of re-assessment:

Household Information/Housing Status

Income/Employment/Transportation/Legal

Medical Coverage

General Medical Information/ Nutrition/ Dental

HIV Specialty Care/Medication Adherence

Social Supports/ Community Resources/ Cultural/ Spiritual

Prevention Needs/ HIV Knowledge/ Risk Reduction Strategies

Safety/Violence

Substance Use/ Addictions

Mental Health

Areas of Need/ Referral

Other/Additional Information

_____
Staff Signature

_____
Date

Appendix G

Clients Rights, Responsibilities, and Grievance Procedure

CLIENT RIGHTS, RESPONSIBILITIES and GRIEVANCE PROCEDURE

As a participant of the Case Management Program at (name of provider), you have the right…

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, ethnicity, national origin, sex, gender identity, sexual orientation, religion, age, class, physical or mental ability.
- To receive information in terms and language that you can understand, and is culturally appropriate.
- To participate in creating a plan for services.
- To reach an agreement with your case manager about the frequency of contact you will have, either in person or over the phone.
- To withdraw your voluntary consent to participate in the Case Management Program at (name of provider) without affecting your medical care or other benefits to which you are entitled.
- To be informed about services and options available to you, including the cost.
- To the assurance of confidentiality of all personal information, communication and records, according to (name of provider) policy.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.
- To file a grievance about services you are receiving or denial of services, according to (name of provider) policy, (see below).

As a participant of the Case Management Program at (name of provider), <u>you have the responsibility</u>…

- To treat other clients, volunteers, and staff of this agency with respect and courtesy.
- To protect the confidentiality of other clients you encounter at (name of provider).
- To be free of alcohol or mind altering drugs while receiving case management services at (name of provider) or on the phone.
- To participate in creating a service plan and to take an active role in resolving that plan.
- To let your case manager know any concerns you have about your case management plan or changes in your needs.
- To make and keep appointments to the best of your ability, or to phone to cancel or change an appointment time, whenever possible.
- To stay in communication with your case manager by informing her/him of changes in your address, phone number, and medical, financial and insurance information, and by responding to your case manager's calls or letters to the best of your ability.
- To refrain from causing physical, sexual, verbal, or emotional abuse or threats to clients, staff, or volunteers.

Grievance Procedure:

If, at any time during the course of your involvement with the Case Management Program at (name of provider), you experience concerns that warrant formal attention, please follow this procedure:

1. Please write or discuss the problem with the staff member with whom you are in disagreement to try to resolve the concern, if possible.
2. If your concern is not resolved, write to or discuss the problem with the staff member's supervisor by contacting _____ at ###-###-####.
3. If your concern is not resolved, write to or discuss the problem with the Executive Director, _____, at ###-###-####. The (title and/or name) will, along with input from you, promptly and appropriately investigate and address the concern. A summary of the concern, as well as the agreed upon plan of resolution, will be submitted in writing by the (title) to you and your case manager within two weeks of the initial grievance.
4. If your concern has not been resolved to your satisfaction after completing this procedure, you may file your complaint in writing with:
   Iowa Department of Public Health
   Ryan White Program, Client Services Coordinator
   321 East 12th Street
   Des Moines, IA 50319

Name _____

I understand the above client rights, understand my responsibilities, and agree to follow them to the best of my ability. I understand the grievance procedure outlined above. I acknowledge that I have received a copy of this form and understand that I may request and receive a copy of this form at any time.

_____ _____

Client's Signature Date

_____ _____

Staff Signature Date

Appendix H.1

Iowa Client Care Plan Option One

Initial Plan Date: _____ **Client:** _____

I agree to work on these goals and objectives as part of the case management process. The action steps are a collaborative effort between the case manager and myself and will be revised and updated as needed for up to one year from the initial date.

Case Mgr Signature: _____ Date: _____

GOAL: _____

OBJECTIVE(S):

WHO	WHAT	WHERE	HOW	WHEN	HOW OFTEN	PROGRESS/ OUTCOME, DATE

Progress Notes:

_____

_____

_____

Initial Plan Date: _____ Client: _____

GOAL:

_____

OBJECTIVE(S):

WHO	WHAT	WHERE	HOW	WHEN	HOW OFTEN	PROGRESS/ OUTCOME, DATE UPDATED

Progress Notes:

_____

_____

_____

Initial Plan Date: _____ Client: _____

GOAL:

_____

OBJECTIVE(S):

WHO	WHAT	WHERE	HOW	WHEN	HOW OFTEN	PROGRESS/ OUTCOME, DATE UPDATED

Progress Notes:

_____

_____

_____

Appendix H.2

Iowa Client Care Plan Option Two

Care Plan

Initial Plan Date: _____ Client Name: _____

My goal to be accomplished by _____ (date) is:
On a scale of 1 to 10, with 1 being "I have so far to go I can't even see where I'm going," and 10 being "I'm already there," I believe I am this close to achieving my goal: 1 2 3 4 5 6 7 8 9 10
This is how I will know I have achieved my goal (what will be different in my life):
These are the barriers I need to overcome to achieve my goal:

These are steps I can take to work toward my goal:	Progress Notes/Dates
1.	
2.	
3.	
4.	
5.	

These are people/organizations who can help me work on my steps, and what they can do to help me:

WHO	WHAT ACTIONS	HOW WILL IT BE DONE	WHEN WILL IT BE DONE	Progress Notes/Dates

This is how and when I will reflect on my progress in order to make adjustments to my plan:

_____ _____

Case Manager Signature Date

Appendix H.3

Iowa Client Care Plan Option Three

Client:

Date:

Issue/Need to be addressed:

SMART Goal #1:

ACTION STEPS:

Specific Steps	**Expected Completion Date**	**Completed**
1)		
Progress: •		
2)		
Progress: •		
3)		
Progress: •		

Client:
Date:
Issue/Need to be addressed:
SMART Goal #2:

ACTION STEPS:

Specific Steps	**Expected Completion Date**	**Completed**
1)		
Progress: •		
2)		
Progress: •		
3)		
Progress: •		

Appendix I

Case Management Enrollment and Client Consent Form

(Name of agency)

Introduction

The Case Management Program is intended to support you, the client, in identifying services and programs that will help you achieve positive health outcomes. A case manager will help you assess and respond to the broad range of physical, emotional, and social needs that individuals living with HIV may encounter. The overall focus will be in ensuring that you receive medical care, but a number of other services may help to achieve this goal. Case Management promotes dignity and self-affirming choices through advocacy and support for personal, familial, and community goals. You are eligible to participate because you are an HIV-infected person living in Iowa and you meet the required income eligibility guidelines.

You may elect to receive case management services at this agency regardless of where you receive your medical care. If you decide to participate in the Case Management Program, you are free to discontinue participation at any time without affecting your relationship with (name of agency) or with any other agencies at which you receive services.

Funding for the Case Management Program comes from the Iowa Department of Public Health (IDPH), which is required to collect certain information to ensure that the program is effective. Participation in the Case Management Program includes allowing your information to be exchanged between (name of agency) and IDPH. The Case Management Program exchanges information with IDPH and by participating in this program you are consenting to this exchange of information between (name of agency) and IDPH.

Data Privacy/Confidentiality

By agreeing to participate in the Case Management Program, you agree to provide information at the time of enrollment and periodically thereafter that will assist in the development of an individualized plan of care and in the evaluation of the Case Management Program. IDPH will have access to information collected as part of the Case Management Program. Examples of this information include:

- Demographic information (name, date of birth, gender, race/ethnicity, address, and phone number);
- Income and eligibility;
- Intake assessment;
- Care plan; and
- Other information related to your history or care.

Your case manager will also have access to information that IDPH collects from medical providers about care of persons with HIV. IDPH collects this information on a regular basis in accordance with Iowa law for reportable diseases. This information will be used to help your case manager monitor adherence to medical care and medications so that you achieve the best possible health outcomes. Examples of this information include:

- The date of your HIV and/or AIDS diagnosis;
- The date and result of viral load tests conducted by your physician;
- The date and result of CD4+ cell counts conducted by your physician.

All information will be maintained in a confidential manner by the Case Management Program with access limited to (name of agency) personnel and to IDPH. Any identifiable information obtained in connection with your participation with the Case Management Program will be released to others (e.g., a doctor's office, hospital, etc.) only with your written consent or as otherwise authorized by law.

Duration of Services

Services within this program are ongoing, depending on level of need and client participation. Services will end when the agreed-upon goals have been met, when funding for this service is discontinued, or when contact between you and your case manager has either ceased or has been determined by either party to be ineffective.

Description of Services

You will be assigned a Case Manager who will assist you with identifying and meeting your service needs. This will occur through a comprehensive intake assessment, in which you will provide personal information about a wide variety of life areas, including current and historical issues. You will then meet regularly with a case manager to develop and implement an individualized care plan based upon the needs identified in the assessment.

There are requirements for the number of times you need to meet with your case manager. This will depend on the level of service you are assigned. There are a number of different levels of service currently offered by the Case Management Program. Clients will enter the service at a level deemed most appropriate by both the client and the intake staff. The initial level of service will be based upon the intake assessment and other information compiled by the case manager. At some time during participation in the Case Management Program, the service level may be changed to best suit your needs.

Closure Policy

There are several reasons that services provided by the Case Management Program may end for a client. They include but are not limited to:

- ✓ The client's stated goals are met and services are no longer needed;
- ✓ The client does not wish to participate in the program regardless of progress on stated goals;
- ✓ The client has not maintained minimum contact as required for the level of Case Management services being received;
- ✓ The client has moved out of state;
- ✓ The client has chosen to receive case management services at an alternate IDPH-funded site;
- ✓ The client has been physically threatening or verbally abusive toward Case Manager or other agency staff; or
- ✓ This agency no longer receives funding for Case Management.

At the time that you and your case manager agree to end your participation in the Case Management Program, you should complete the closure form to withdraw your consent for participation.

Client's Statement

By signing below, I acknowledge that I have read and understand the above information and agree to receive services provided by this Case Management Program under the conditions stated above. I may, without consequence, withdraw my participation from the program at any time after signing this document. I may request and receive a copy of this signed consent form at any time. Any and all copies of this document are to be considered as binding as the original. By signing below, I agree that (name of agency) and IDPH may exchange information as described above. I specifically authorize the release of HIV-related information, mental health information, and substance abuse information. I hereby acknowledge that I have received copies of this consent form. This consent is valid for one year from the date of signature. However, consent may be withdrawn in writing at any time that services are discontinued.

Client Signature Date

_____ _____

Client Name (Please Print)

_____

Case Manager Signature Date

_____ _____

Appendix J

Consent to Release Confidential Information

Consent to Release of Confidential Information

Client Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize **Insert Name of Agency** to release the following information:

- ☐ Care Plan
- ☐ Intake and Assessment
- ☐ Other: _____
- ☐ Lab Reports (CD4 Count/Viral Load)
- ☐ Case management notes

TO: _____

_____

This information may include, but is not limited to ***(Place Yes, NO or N/A beside all categories)***:

_____ HIV Disease information and/or records

_____ Mental Health information and/or records

_____ Substance Use information and/or records

The information is to be used for the delivery of case management services only.

This authorization allows release of information for a period of two weeks from the date of execution of the release, unless otherwise specified.

I understand I have a right to inspect the disclosed information at any time.

I understand I may revoke this authorization at any time, yet I may not revoke authorization for information that has been released up to the point of my revocation. Any revocation must be in writing and delivered to the appropriate individuals listed above.

I understand Iowa and/or federal laws prohibit re-disclosure of confidential information to individuals outside of **Insert Name of Agency** without my written authorization. I also understand that **Insert Name of Agency** staff members may, without further authorization, re-disclose information amongst their case management team.

Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:

This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

A photocopy of this signed Authorization will have the same validity as the original.

I herby authorize the release of information as indicated above. _____ (initial)

I acknowledge I have received a copy of this documentation. _____ (initial)

Executed this _____ day of _____, 20_____. **X** By: _____

Signature

Appendix K

Consent to Exchange Confidential Information

Consent to Exchange of Confidential Information

Client Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize **Insert Name of Agency** to exchange or discuss the following information:

- ☐ Scheduling Information
- ☐ Ongoing medical care issues
- ☐ Case management issues
- ☐ Other: _____
- ☐ Lab test values (e.g., CD4 Count/Viral Load)
- ☐ Medications, side effects, and adherence
- ☐ Substance use and mental health

WITH: _____

_____

This information may include, but is not limited to ***(Place Yes, NO or N/A beside all categories)***:

_____ HIV Disease information and/or records

_____ Mental Health information and/or records

_____ Substance Use information and/or records

The information is to be used for the delivery of case management and the improvement of health outcomes.

This authorization will automatically expire one-year from the date of signature, unless otherwise specified. If other expiration date, specify: Day _____ Month _____ Year_____. Upon expiration, no express revocation shall be needed to terminate my consent. I understand that I may revoke this consent at any time by sending a written notice by certified mail to: **Insert Name of Agency**

I understand I may revoke this authorization at any time, yet I may not revoke authorization for information that has been released up to the point of my revocation. Any revocation must be in writing and delivered to the appropriate individuals listed above.

I understand Iowa and/or federal laws prohibit re-disclosure of confidential information to persons outside of this agreement without my written authorization. I also understand that **Insert Name of Agency** staff members, without further authorization, may re-disclose information amongst their case management team.

Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:

This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

A photocopy of this signed Authorization will have the same validity as the original.

I herby authorize the release of information as indicated above. _____ (initial)

I acknowledge I have received a copy of this documentation. _____ (initial)

Executed this _____ day of _____, 20_____. **X** By: _____

Signature

Appendix L

Ryan White Part B Case Management Discharge Summary

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Ryan White Part B Case Management Discharge Summary

This form is to be completed when a client is discharged from Medical or Non-Medical Case Management, faxed to IDPH, and kept in the client's Ryan White file

Date:_____

TO: Elizabeth McChesney; Bureau of HIV, STD, & Hepatitis **FAX:** 515.281.0466

Client Name:_____ **Client ID (if applicable):**_____

Agency:_____ **Case Manager:** _____

Date of Discharge: _____

Date of Last Annual Assessment: _____

Reason for Discharge (also used as client's enrollment status in CAREWare)**:**

Unknown (client has been lost to care)**:** ☐
Referred or Discharged
Referred to another program in Iowa: ☐
Referred to a program outside of Iowa: ☐
Client Request: ☐
Removed (removed due to violation of rules): ☐
Incarcerated: ☐
Relocated:
Moved within Iowa: ☐
Moved outside of Iowa: ☐
Deceased: ☐

Discharge Notes How the client's situation changed causing discharge (i.e. new location, new job with pay over Ryan White income guidelines, etc.)**:** _____

Services Provided: _____
_____
_____

Discharge Check List:
Has ADAP discharge form been completed? ☐ **Yes** ☐ **No** ☐ **N/A**
Has CAREWare been updated to reflect client's new enrollment status? ☐ **Yes** ☐ **No**

Case Manager Signature: _____
Date: _____

May 2016