

Standards of CARE for Ryan White II funded

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SECTION I
CASE MANAGEMENT STANDARDS

Standards of Care for Ryan White II-Funded
Case Management Services

Individuals living with HIV infection are often faced with a multitude of issues that, if not addressed in a timely manner, can result in negative health consequences. These issues include, but are not limited to, medical care, transportation, emergency housing, food, support groups, mental health counseling, etc. Obtaining these services is often difficult for these individuals in light of the complex, fragmented and usually unfamiliar service delivery system. A person may receive assistance in securing these critical services through what is commonly referred to as "case management."

The U.S. Department of Health and Human Services, HIV/AIDS Bureau, Health & Resources Service Administration (HRSA) defines case management as: "A range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include, but may not be limited to:

- Initial comprehensive assessment of the client's needs and personal support systems;

- Development of a comprehensive, individualized *service plan*;
- Coordination of the services required to *implement the plan*;
- Client *monitoring* to assess the efficacy of the plan;
- *Periodic re-evaluation* and revision of the plan as necessary over the life of the client; and,
- Client-specific advocacy and/or review of the utilization of services.

Goals: The goals of case management are to: optimize client functioning by facilitating quality services in the most efficient and effective manner; and, support keeping all clients connected to care.

1.0 Case Manager Roles and Responsibilities

The Case Manager will:

- 1.1 Maintain a professional therapeutic relationship with the client.
- 1.2 Conduct an intake into care, including an initial assessment of client strengths and needs and the development of a comprehensive service care plan.
- 1.3 Conduct ongoing assessment of client needs incorporating client feedback and input at least every six months.
- 1.4 Conduct ongoing service planning, including re-evaluation and updating.

- 1.5 Provide direct provision of appropriate services.
- 1.6 Negotiate realistic goals with client within realistic time frames.
- 1.7 Monitor client's progress to meeting established goals of care.
- 1.8 Advocate for the client to ensure access to appropriate, culturally competent services.
- 1.9 Make referrals and link clients to other appropriate resources.
- 1.10 Create and maintain resource and referral networks.
- 1.11 Follow up with client's service provider regarding referrals.
- 1.12 Coordinate service delivery in a timely manner
- 1.13 Document activities regularly in progress notes.
- 1.14 Define role expectations and tasks of both the case manager and client throughout the entire case management service agreement.
- 1.15 Operate with an exchange of dignity and respect between the case manager and client.
- 1.16 Protect the oral, written and electronic confidentiality of the client.
- 1.17 Participate in case conferences to sustain or improve client quality of life.

1.18 Inform the client of agency and grievance policies and procedures.

1.19 Foster independence by reviewing the assessed need at least every six months.

2.0 Service Delivery

2.1 The case manager will inform clients that they are eligible for case management services free of charge.

2.2 The case manager will conduct a face-to-face assessment of the client's needs. The assessment must include, but may not be limited to:

- financial status
- health history
- name of client primary medical provider
- Viral Load (VL) & CD4 test results
- relevant laboratory & psychological test history
- medical/insurance status
- psychosocial supports
- transportation barriers
- basic needs (clothing, etc.)
- nutritional status
- housing
- behavioral health and substance abuse

- HIV medication adherence
 - need for referrals to other services & outcome of referrals
- 2.3 The assessment should be reviewed with the client for the purpose of developing a mutually agreed upon Service Plan. An assessment of the client's needs should be assistance with payments for services, certain steps need to be taken prior to updated at least every six (6) months.
- 2.5 If the client requests authorizing such payment. *(Section III, Administrative Policies and Procedures)*.
- 2.6 All clients who request or are referred for HIV case management services will be contacted within two (2) business days after a referral has been received. Every effort should be made to meet with a client within five (5) business days.
- 2.7 If a client cannot meet with the case manager at an agency, the case manager should attempt to meet the client at a location accessible and appropriate for the client (e.g., home, shelter, with family, etc.)
- 2.8 Intake information will be obtained within forty-eight (48) hours of referral to the case manager. Other related forms should ideally be completed within two (2) weeks of the intake, but must be completed in no more than four weeks.

2.9 All client information must be updated at least every six (6) months from the time the basic information was obtained. HIV Viral Load (VL) and CD4 tests

*Circumstances that necessitate a deviation from this time frame should be documented in the progress note of the client record (e.g., client is unable to be contacted by phone or by mail, no permanent housing, relocation, incarceration, etc.)

3.0 Service Plan

- 3.1 The case manager will develop a Service Plan with the client to insure that the identified needs are addressed for every client enrolled in case management. Case managers must ensure that all client needs are identified and prioritized so that the most important services for clients are made available as soon as possible. Plans should incorporate client needs, preferences, and the client's strengths and limitations (*Section IV, Forms*).
- 3.2 Preliminary Service Plans should be completed at the first face-to-face meeting with the client. A comprehensive Service Plan should be completed within five (5) business days.
- 3.3 The Service Plan is an ongoing process and should be reviewed on an as needed basis, as determined by the case manager, but no less than every six (6) months.
- 3.4 The Service Plan should be signed by the case manager developing the plan and signed by the client. The client's signature confirms that the client understands the plan.
- 3.5 The client will initial each goal on the Service Plan to indicate agreement to work collaboratively toward goal completion.
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4.0 Progress Notes

- 4.1 A progress note must be done on a client *at least monthly*.
 - 4.2 The person making the progress note entry must use his/her full legal name and title. The entry must also be dated and entered in a timely manner after an interaction with the client.
 - 4.3 The case manager will document the progress on meeting the goals addressed in the Service Plan in the clients record/progress note section.
 - 4.4 The case manager will document efforts to contact the client as needed (e.g., to update client information, reassess service care plan, assess completion of referral, etc.)
 - 4.5 The case manager should not leave blank spaces between progress notes.
-

5.0 Documentation

- 5.1 All provider agencies who offer case management services must have a client record system that includes consistent and standardized ways of collecting and maintaining information including, but not limited to, client demographics, assessments, services plans, treatment/services provided, client response to services, updates, treatment

goals, and verification of Viral Load and CD4 test results. Information must be updated every (6) six months.

- 5.2 Contents of the client record shall be protected within the parameters of State and federal laws.
- 5.3 Case managers must use DPH, AIDS and Chronic Diseases Section, HCSS- required forms.
- 5.4 Case managers performing a client intake must complete the URS, General Intake Form and the Case Management Intake Form. These forms should be printed out from URS and placed in the file. The case manager must also fill out the Eligibility Worksheet (page 3 of the old Client Intake). Other information about the client can be recorded through the following URS forms that can be attached to the General Intake Form and the Eligibility Worksheet, *if applicable*: Medical History, Insurance History, Substance Use History, HIV-Risk History, Collateral Information, etc. If a referral is made for the client, this referral must be entered into URS. A referral form may be generated from URS and placed in the client record.
- 5.5 The required fields in URS for a regular client intake are:
 - a. 1st 2 letters of last name (or full last name)
 - b. 1st 2 letters of first name (or full first name)

- c. State
- d. County
- e. Zip Code
- f. Hispanic (Y/N)
- g. Race
- h. DOB
- i. Sex
- j. Housing Status (12 choices)
- k. Primary Language (26 choices)
- l. Referral Source (17 choices)
- m. Insurance (Y/N/Unk)
- n. Intake Date
- o. Intake Worker
- p. Program
- q. Site
- r. HIV Viral Load & CD4 test results*
- s. Client's Medical Provider*

*Department of Public Health, AIDS & Chronic Diseases Section, Health Care Support Services Unit

6.0 Continuum of Care and Making Referrals

Goal: All clients identified as needing a referral to improve health will complete the referral.

- 6.1 The case manager must assess the need for a referral during the intake process as well as any accompanying transportation needs.
 - 6.2 The case manager must assess the client for early referral and linkages to risk reduction services (*Section IV, Forms*).
 - 6.3 The case manager will document referral information in the progress note section of the client record:
 - a. Name of person or agency client is referred to
 - b. Reason for the referral
 - c. Referral status
 - d. Client accepted referral
 - e. Client rejects referral
 - f. Placed on a waiting list
 - g. Ineligibility to receive services from referral source
 - h. Appointment date and time
 - i. Barriers to completing referral
 - j. Completion date of referral
 - k. Any new assessed needs as a result of the referral
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7.0 Eligibility

Goals: a) All eligible clients and their families who seek assistance with health and supportive services will be given assistance. b) Title II funds will be used as the payer of last resort. *

7.1 The case manager will provide case management services free of charge to PLWH and their families (married and unmarried heterosexual and same sex couples, and any dependents living with them).

7.2 The case manager must complete an intake for all clients who receive case management services.

7.3 If a client requests Title II funds for health or health related needs, the case manager must secure documentation of the client's HIV status *prior to* approving funding for services. Acceptable sources for HIV documentation are one of the following:

- *HIV Test Results:* A copy of a seropositive blood test for antibodies to HIV: ELISA (Enzyme Linked Immunosorbent Assay) confirmed by western blot assay with the client's name on the test report.
 - A *confidential* test result from a State-funded Counseling and Testing site is acceptable; an *anonymous* test result is not acceptable.
 - A test result generated by a licensed medical provider. *
- *Documentation from a medical provider:* A signed letter or medical progress note from a licensed provider with identified agency/medical provider logo stating that the client has HIV/AIDS.

Copy of the CADAP Application: A copy of the CADAP (CT AIDS Drug Assistance Program) application signed by a medical provider.

- 7.4 Other forms of documentation require approval from the RW II Quality Assurance Nurse Consultant.
- 7.5 If necessary, the case manager should assist the client in securing HIV documentation to expedite the process (e.g., signing release of information for documentation, sending letter to provider for HIV documentation, etc.).
- 7.6 Title II-funded agencies may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Title II funded services. CARE Act grantees or contractors may refer eligible veterans to the VA for services when appropriate and available. However, CARE Act grantees or contractors may not require that eligible veterans access VA care against their will.
- 7.7 The case manager will use the "Client Eligibility Worksheet" to demonstrate client eligibility for health and supportive services (*Section IV, Forms*).
- 7.8 Verification that the client meets the 300% FPL current eligibility requirement must be obtained prior to payment for services (e.g., unemployment stub, Title XIX, Medicare, Social Security Income, Social Security Income Disability, income tax return, State Administered General Assistance, etc.).
- 7.9 Client eligibility must be determined every six months or *whenever there has been a change in a client's financial circumstances*. Proof of eligibility must also be obtained at that time.

7.10 If the client is requesting Title II funds for services not covered by Title XIX or another medical insurer, documentation must be provided indicating that the service was not an allowable service under the health plan.

*In general, Medical provider is defined as a Medical Doctor, MD or Physician's Assistant, PA or an Advanced Practice Registered Nurse, APRN. If the client was in a CT correctional facility, a Licensed Practical or Registered Nurse's (LPN or RN) signature is acceptable as documentation of the client's HIV status.

7.11 Medical and health-related, out-of-pocket expenses should be taken into account as adjustments in determining a client's eligibility. Medical expenses taken into account must be within a 12-month period of time and can only be used to calculate and pay for current and future bills submitted to a Title II program (case manager). Examples of health expenses are:

- Medical provider visits (including co-payments)
- Health insurance premiums
- Health insurance deductibles
- Medical supplies
- Prescriptions

7.12 If the client is here illegally or is a migrant worker, he or she may still be employed. Efforts should be made to secure documentation that the client does not have an income (e.g., letter from friend, family member).

7.13 The case manager must submit a request for payment of services on the "Ryan White

Payable Services" form the Program Supervisor (*Forms, Section IV*). Make sure to include the name of the agency denying the payment or stating that the service is unavailable.

8.0 Confidentiality

Goal: Clients right to privacy will be safeguarded and respected in accordance with federal and State laws (CT General Statutes 19a-581-590 and 592).

- 8.1 Case managers must respect the clients' right to dignity and humane treatment.
- 8.2 All clients must be given the opportunity to read, as well as understand, the confidentiality agreements between client and the Title II-funded agency.
- 8.3 The case manager must assure that when a client or the client's legal guardian signs a *Release of Information*, the client/legal guardian *understands* that information from his record will be shared and with whom and for what purpose.
- 8.4 The client has a right to know for what period of time the disclosure will occur and what safeguards are in place against unauthorized disclosure.
- 8.5 Communication made on the client's behalf should safeguard the client's right to privacy (face-to-face conversations, telephone communications, faxing or e-mailing client identifying information).

SECTION II

HEALTH AND RELATED STANDARDS

9.0 Primary Care and Specialty Services

Goal: Clients will have health and health related services delivered in accordance with most recent recommendations published by the *U.S. Public Health Service, Guidelines for the Use of Antiviral Agents in HIV Infected Adults and Adolescents** and other nationally recognized standards of clinical care (*Website: <http://AIDSinfo.nih.gov> Phone: 1-800-448-0440 TTY: 1-888-480-3739 Fax: 1-301-519-6616

9.1 The client receives comprehensive health care to the extent that the services provide:

- Prevention of further disease progression
- Prevention of new illness or disease
- Urgent/acute care
- Pain management
- Behavioral and substance abuse services
- Rehabilitative and palliative care

9.2 Examples of the type of services paid for with Title II funds:

- Complete medical history and physical examination
- Psychosocial assessment
- Nutritional Assessment
- Ophthalmic or Optometric Examination
- Gynecological examinations
- Sexually Transmitted Disease (STD) screenings
- Laboratory tests and diagnostic procedures to prevent Opportunistic Infections (OIs) such as:
 - o Complete blood count and chemistry profile, including serum transaminases and lipid profile
 - o HIV Viral Load Test (Plasma HIV RNA measurement)
 - o CD4+ T lymphocyte count
 - o Purified Protein Derivative of Tuberculin (PPD) test with an anergy panel,
 - o Hepatitis B and C Serology
 - o Liver Function Tests
 - o Venereal Disease serology tests (e.g., RPR, VDRL, Chlamydia)

- o Toxoplasmosis or Cytomegalovirus serology
- o Drug Resistance Testing (genotyping and phenotyping)
- o Urinalysis
- o Chest x-ray

9.3 Refer clients to specialty services as deemed necessary.

9.4 Monitor client compliance with medical treatment and follow-up visits.

9.5 Home health service shall include, but may not be limited to: home health aide assistance, homemaker services, skilled nursing services, infusion therapies, durable medical equipment as deemed necessary.

9.6 Home health services shall be provided only when all of the following conditions are met:

- A physician's order has been issued indicating that the client needs the specific services;
- Services must be provided in the client's home; and,
- The required services cannot be reimbursed by any other benefit or entitlement program available to the client.

The client is unable to pay for the services directly.

- 9.7 All services must be furnished by a provider licensed within their prospective discipline.
- 9.8 All pharmaceuticals and medical supplies ordered by a licensed provider must be accompanied by a prescription (written order). A copy of the order should be kept in the client's record.
- 9.9 Health care should be administered in a culturally competent environment.
- 9.10 Health care should be coordinated with other community health providers when necessary.
- 9.11 Clients should be encouraged to establish a relationship with a provider and should be offered the necessary supports to continue the relationship over time.
- 9.12 Title II funds must be used as the payer of last resort.
- 9.13 If a service is in question, the case manager must contact the Nurse Consultant in the HCSS unit.

10.0 Mental Health and Substance Abuse Services

Goal: Clients who need mental health or substance abuse services will receive the services.

- 10.1 Funds may be used to provide psychological, mental health and psychiatric treatment, including individual, couples, family and group counseling, crisis intervention and psychological testing provided by a licensed mental health professional or individual with

authority to provide services in accordance with the Connecticut General Statutes.

- 10.2 Funds may only be used to pay for a client's initial enrollment in a State- funded Methadone Treatment Clinic. If there are extenuating factors that influence a client's ability to sustain enrollment, the CASE MANAGER must discuss these factors with the HCSS Contract Manager or QA Nurse Consultant.
- 10.3 The case manager will conduct a screening of mental and behavioral health issues that have the potential of impairing the client's ability to maintain or improve his/her health care.
- 10.4 A request for a client referral to mental health services can be made by a case manager, a health care provider, one's self or others (e.g., family, friends, etc.).
- 10.5 The case manager will document the status of completing the referral and monitor the client's progress in following the treatment plan (if applicable).
- 10.6 All psychiatric and psychological diagnoses and other related information must be safeguarded and not shared without the client's consent.

For Agencies Funded to Provide Mental Health Services

- 10.7 Mental health treatment services shall be provided by professionals or agencies that meet licensure requirements of the State of Connecticut.

- 10.8 Each provider shall inform the client of the nature of the services offered, including the right to engage in developing treatment plan goals, limits of confidentiality and his or her ability to terminate services at any time.
- 10.9 Each treatment provider shall ensure that a client participates in his or her own treatment plan.
- 10.10 Providers will have a mechanism in place to track the client's progress in meeting his/her treatment plan goals.
- 10.11 Each treatment provider shall ensure that the client understands and signs an informed consent and treatment form.
- 10.12 The provider must work collaboratively with the client's case manager to secure access to mental health services.
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11.0 Dental Services

Goal: Clients who are referred for dental services will receive an initial dental examination and exams at least bi-annually thereafter.

- 11.1 Dental services must be provided by dentists and dental hygienists licensed in the State of Connecticut.
- 11.2 Clients shall receive dental care that meets the established and most current clinical standards

and practices of dental and oral care and HIV disease management (e.g., American Academy of Oral Medicine and the American Dental Association).

- 11.3 Dental care and treatment shall be provided thorough routine restorative and preventative services including specialty consultation when required.
- 11.4 Dental services include preliminary examinations, x-rays, diagnosis and treatment, follow-up monitoring of conditions, and emergent care. Specialty consultations include, but may not be limited to, partial dentures, full dentures, complex oral surgery, or periodontal care/surgery as required.
- 11.5 Preventative services include oral and dental exams, cleaning and prophylaxis, fluoride treatments, and oral hygiene instructions.

12.0 Complementary Therapies

The needs of people with HIV infection are compounded by the complexities of their medical care, and the likelihood of precipitous changes in their physical and emotional status throughout the course of the illness. Complementary therapies provide an adjunct to, not a substitution for, primary medical care services in order to optimize the benefits of medical care and treatment and to enhance quality of life.

Goal: The goal of complementary therapy is improved quality of life for individuals with HIV infection through

reduction of symptoms and the enhancement of client health and well-being.

- 12.1 Agencies must ensure that all clients accepted for services meet the minimum eligibility requirements defined by HRSA and the applicable EMA.
- 12.2 Agencies must ensure that the client's primary medical care provider (or substance abuse counselor in the case of referrals for acupuncture associated with substance abuse treatment) has determined that complementary therapy is indicated. This determination must be reviewed annually.
- 12.3 Agencies must have a written job description with specific minimum qualifications outlined for complementary therapists whether employed directly or as sub-contractors.

Once hired, complementary therapists will participate in HIV/AIDS orientation training.
- 12.4 All complementary therapists must be licensed and accredited by appropriate local, State, and/or federal agencies as required for specific disciplines and must follow standards of practice endorsed by their specific disciplines.
- 12.5 All complementary therapy staff will be provided with ongoing and consistent supervision addressing administrative, programmatic and staff support issues.

- 12.6 All complementary therapists hired by provider agencies will be able to complete documentation as required by their position (at a minimum, intake, assessment, and service delivery and goal forms).
- 12.7 Agencies must assure compliance with Occupational Safety and Health Administration (OSHA) infectious disease prevention guidelines for the designated complementary therapy (acupuncture, massage, etc.) at all locations where services are provided.
- 12.8 Agencies must have written policies for client confidentiality and release of information that are in accordance with State and federal laws. As part of the confidentiality policy, all agencies will provide a "release of information" form describing the circumstances under which client information can be released.
- 12.9 Agencies must have written policies for a client grievance procedure. Each agency will have a policy identifying the steps a client should follow to file a grievance and stating how the grievance will be handled.
- 12.10 All clients who request or are referred for complementary therapy services will be contacted within 5 business days after a referral has been received, and a face-to-face appointment will be scheduled within 15 business days.
- 12.11 At the initial client assessment meeting, all clients must be informed of services provided, the role of the complementary therapist, and

the agency's client confidentiality and grievance policies. If the client is eligible for services and chooses to enroll in complementary therapy he or she will provide information and sign any necessary forms for release of information.

12.12 Every client enrolled in complementary therapy will be assessed (and reassessed at least every six months). At a minimum, the following areas will be included and documented in the client assessment/ reassessment:

- medical history, current health status, current health care provider(s);
- symptoms/conditions for which client is receiving treatment;
- appropriateness for relapse prevention treatment and substance use assessment in relation to relapse prevention, if applicable.

12.13 A treatment plan will be developed for every client enrolled in complementary therapy and completed within one week of the initial assessment meeting. Treatment planning is an ongoing process. It is the responsibility of the complementary therapist to continually review and revise a client's treatment plan. Treatment plans should be reviewed on an as-needed basis, as determined by the complementary therapist, but no less than every six months.

12.14 At a minimum the treatment plan should include:

- description of the problem(s)/symptom(s)/condition(s)
- short and/or long term goals for treating each symptom
- nature and level of treatment need
- time frames within which treatments are to be provided

12.15 Agencies will have a written protocol in place to notify clients of upcoming appointments while respecting client preferences and confidentiality.

12.16 Agencies will have a written protocol in place to deal with clients who do not show up for appointments.

12.17 Clients shall be considered inactive if they have not made contact or have not received a service for a period of six months.

12.18 Agencies must clearly publicize how, when and where clients may receive services, including:

- Hours of operation (including accessibility during evening and weekends)
- Telephone numbers
- Availability of culturally and linguistically appropriate services

- Availability of telephone consultations
- Availability of appointments within a maximum allowable time
- Physical location(s) of services
- Availability of transportation
- Accessibility for people with disabilities

12.19 Agencies must have a client record system that includes consistent and standardized ways of collecting and maintaining information about client demographics, treatment/services provided, client response to services, updates in treatment, treatment goals and other pertinent information and that assures confidentiality within parameters of State and federal law. The client record system must allow for the aggregation of client information.

12.20 Complementary therapists are responsible for documenting the goals of their clients' treatment. Progress notes regarding treatment plan implementation are to be completed at the time of the service delivery.

12.21 Agencies must have a system in place to obtain information on client demographics, client satisfaction, service quality, and client goals.

12.22 Agencies offering complementary therapy services will document that clients have been

informed of confidentiality policies and grievance procedures.

12.23 All provider agencies offering complementary therapy services must have a

system in place to review on a regular basis, the types and levels of services provided to clients.

12.24 Each client is reviewed by the complementary therapist at least every six

months to determine the appropriateness of the service.

12.25 Aggregated information from client service reviews is reviewed at least

annually and used to enhance program design.

12.26 Agencies must have a quality improvement process that identifies areas

requiring review, develops and implements corrections, and documents the responses to the corrections.

13.0 Nutritional Services

Goal: Clients will report improved nutritional status over time such as increased weight and improved HIV medication adherence. Objective data should be collected and recorded to support this goal.

13.1 Nutritional support can be provided to Title II-eligible clients through several different venues:

- Salaries for a Licensed Dietitian (Registered Dietitian/R.D.) or other licensed health care provider (e.g., Registered Nurse, Advanced Practitioner Registered Nurse)
- For food vouchers
- For food supplies accessible to clients (e.g., food pantry, food kitchen, food bank)
- Payment for Nutritional Supplements NOT provided through the State's Nutritional Supplement Program (*Section IV, Resources*)

General Nutrition Standards

- 13.2 All clients who access Nutrition services must be eligible under Title II.
- 13.3 Title II funds must be used as the payer of last resort.
- 13.4 Providers agree to coordinate services with other local food banks or food kitchens to avoid duplication of services.
- 13.5 Agencies providing nutrition/food to clients must comply with all applicable local, State, and federal regulations (e.g., storage and handling).
- 13.6 Congregate meal menus are prepared in consultation with a Registered Dietician or licensed health provider following guidelines

outlined in ***Health Care and HIV Manual: Nutritional Guide for Providers and Clients***, a publication supported by the Health Resources and Services Administration.*

13.7 Providers will make every effort to purchase culturally-appropriate/nutritious food for clients.

13.8 Agencies have written policies and procedures included, but not limited to, monitoring food safety, equitable distribution of food, adequate portions of food, and the availability of a schedule of food services. Providers shall have a system in place to monitor internal agency nutrition policies and procedures.

13.9 Home delivered meals must be prescribed by the client's health provider and prepared in conjunction with a Registered Dietician or other qualified health care provider.

Roles and Responsibilities for Title II funded Nutrition Staff

13.10 Services will be provided by a Registered Dietician or appropriate qualified

licensed health care provider. Services will include, but may not be limited to:

13.11 An assessment of client's dietary intake, cultural food preferences,

weight and height, medications, allergies, chronic diseases history,

complimentary therapies, nutrition-related symptoms (e.g., diarrhea, nausea,

vomiting, poor dental care, difficulty swallowing, etc.), socio-economic factors

affecting nutrition, changes in body shape, nutritional education/counseling

needs, etc. (Section VI, Resources, Quick Nutrition Screen Tool Example).

13.12 A Nutritional Care Plan (NCP) that includes client goals, objectives, how the

Plan will be monitored and within what measurable time frames.

13.13 The NCP should contain medically and culturally relevant recommendations

and be integrated in the client's overall health care plan.

13.14 The NCP is developed with the involvement of the client and signed by the

client.

13.15 The client understands and is offered a copy of the NCP.

13.16 The NCP will be reassessed every six months or earlier if necessary.

Food Vouchers

13.17 Clients must be assessed and determined to need food or nutrition.

(per Standard 2.2)

13.18 Food Vouchers are used as the payer of last resort, and;

13.19 Clients may only access funds to pay for food through prepaid Food Vouchers in a face-to-face contact with his/her case manager (e.g., gift certificates from local grocery stores).

13.20 Food Vouchers should be used for food and nutritional items only, such as meats/fish, fruits and vegetables.

Food Banks, Kitchens, Pantries

13.21 See General Nutrition Standards (13.2-13.8)

14.0 Pharmaceutical Services

Pharmaceutical Services are defined as: medications, drugs, or treatment formularies that prevent medical complications, side effects of HIV-related medications and promote health.

Goal: All eligible clients who need HIV-related medications and/or treatments will receive them.

14.1 Title II funds may only be used for Food and Drug Administration (FDA) approved drugs/medications.

14.2 The medication or treatment must be HIV-related. Classes of HIV-related drugs commonly prescribed are listed in the *CADAP Formulary*:
<http://www.ct.gov/dss/site/default.asp> click on publications

14.3 Funds awarded under Title II of the CARE Act may not be used to support the costs of operating clinical trials of investigational agents or treatments (to include administrative management or medical monitoring of patients). However, funds may be used to support participation in clinical trials and in

expanded access and compassionate use programs.

14.4 Funds may not be used to pay for drugs prescribed to enhance sexual performance.

14.5 All medications or treatments paid for through Ryan White Title II funds must be prescribed by a licensed medical provider.

14.6 All prescriptions must be filled by a registered pharmacist and a licensed pharmacy.

14.7 A copy of the client's prescription from a medical provider or the pharmacist must be found in the client record. Documentation must include the name of the client, the medication and the prescribing medical provider.

14.8 If the medication is not specifically used to treat HIV disease, accompanying documentation from the client's medical provider must be obtained. Documentation should include the relevance of the medication/treatment to the client's HIV status.

14.9 The case manager will assess the client's need for pharmaceuticals services.

14.10 Documentation that an assessment of the client's pharmaceutical needs must be included on the "Assessment of Client Needs" form.

14.11 The Service Plans must address identified pharmaceutical need(s) for the client; the plan

should be negotiated with the client and monitored by the case manager.

- 14.12 If a client is CADAP eligible, the case manager must assist the client with processing a CADAP application

<http://www.ct.gov/dss/site/default.asp> click on publications/applications).

- 14.13 If client is CADAP eligible, but has not received approval to access the CADAP, Title funds may be used to pay for the client's medication(s).
-

15.0 HIV Medication Adherence

- 15.1 All clients will be assessed for the capacity to adhere to HIV medications.
- 15.2 Case managers should use the *Case Manager Guidelines for Assessing Clients' HIV Medication Needs* to assess the need for a referral to an HIV Medication Adherence Program (MAP) at each assessment meeting (*Section IV, Forms*).
- 15.3 The case managers should have a mechanism to obtain updated information about MAPs in their region.
- 15.4 The case manager should address barriers to HIV medication adherence at every encounter with the client (e.g., use concepts listed on DPH lanyard as triggers, etc.)

- 15.5 The case manager must address assessed HIV medication adherence needs on the client's care plan.
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16.0 Child Care

- 16.1 Title II funds may be used for care of children in these instances:
- 16.2 To support a licensed or registered care provider for intermittent or continuing care of HIV+ children; and,
- 16.3 To enable an infected adult or child to secure needed medical or support services through support to a licensed or registered provider of child care to infected or non-infected children, and/or support for informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to individuals to pay for these services).
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17.0 Day or Respite Care for Eligible Individuals

- 17.1 Funds awarded under Titles I or II of the CARE Act may be used for day care or respite care in the following instances:

- a. to support a licensed or registered provider of continuing day care for HIV+ adults or children;
 - b. to enable an infected adult or child to secure needed medical or support services through: (1) support to a licensed or registered provider for day care for an infected adult; or, (2) support for informal adult day care provided by a neighbor, family member, or other person (with the understanding that existing Federal restrictions prohibit giving cash to an eligible individual to pay the neighbor or family member for this service); and/or,
 - c. to provide periodic and time-limited respite for the caregiver(s) of infected adults or children which is necessary to support the caregiver in continuing those responsibilities.
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18.0 Transportation Services

Goal: All Title II-eligible clients will have access to medical care, mental health care, substance abuse treatment, and other needed support services.

18.1 Role and Responsibility of Transportation Provider

- 18.2 Agency staff are qualified and trained for the responsibilities and duties of administering the transportation program.
- 18.3 The agency has a comprehensive policy and procedure manual that contains standardized protocols for transportation service delivery, transportation service limitations, eligibility requirements and transportation service agreements with transportation service operators and providers, including licensing, registration, insurance and safety requirements and necessary action to be taken in the event of an accident.
- 18.4 All reasonable safety precautions are followed including seat belt usage, vehicle maintenance and inspection and child care safety.
- 18.5 Licensed operators understand their responsibilities and agree to follow agency policy in the event of an accident.
- 18.6 Service Delivery
- 18.7 Clients have an appropriate mix of transportation services available to meet the full variety of transportation needs of clients.
- 18.8 Transportation will be provided with 24-hour prior notification. Clients will be informed of delays or changes in scheduled transportation services in a timely manner. Every reasonable effort will be made to provide emergency transportation.

- 18.9 Directions on how to access transportation will be available in a culturally and linguistically appropriate manner for all clients. The directions will include policies and procedures for communicating delays or changes in transportation services.
- 18.10 Transportation is to be used for persons going to and from appointments for medical care, substance abuse treatment, mental health counseling and other support services, but may not be used for social or recreational purposes.
- 18.11 Title II transportation funds may be used to purchase a gas card for a friend or family member for transporting a client to and from appointments at the prevailing State rate per mile. Documentation of the concluded appointed form physical/provider is required and reimbursements can only be made in tokens, gas cards or the like, not in cash.
- 18.12 Title II transportation funds may be used for parking expenses for qualified and documented appointments.
- 18.13 Documentation
- 18.14 A clearly defined data tracking system is in place to account for all transportation services and expenditures.
- 18.15 A mechanism is in place to verify that clients have kept the appointment for which transportation was provided.

18.16 Administration

18.17 There is a system in place to obtain periodic feedback from staff, service providers and clients on services and how they can be improved.

18.18 Title II funds are payment of last resort and may only be used to provide

Transportation when no other transportation is available to the client.

18.19 Transportation paid for with Ryan White funds must be provided in the

most cost-efficient manner.

18.20 Rates for services should be negotiated with local subcontracted

transportation providers where possible.

18.21 Title II transportation funds may be used for persons living with HIV to

attend consortium meetings. Use of transportation funds for this purpose

should not be counted against the client's transportation funds cap.

18.22 Agencies that administer Title II-funded transportation services will disseminate information about the availability, eligibility requirements, and referral mechanisms for the transportation services to all

organizations providing care for persons with HIV.

19.0 Emergency Non-Medical Services

Goals: Clients eligible for Title II receive assistance with emergent needs to the extent that the service supports, facilitates, enhances, or sustains the continuity of benefits of health services for these individuals and their families. Services include, but may not be limited to: utility assistance to prevent discontinuance of electricity, telephone or heating; emergency housing; emergency rental assistance; transportation; continuation of medical insurance, insurance co-payments or food.

- 19.1 Documentation of a client's HIV status and financial eligibility must be verified prior to accessing Title II emergency assistance funds.
- 19.2 Documentation of utility shut off notices must be obtained prior to accessing Title II emergency assistance funds.
- 19.3 Funds may be used to pay for insurance premiums and co-pays to the extent that these funds are used as the payer of last resort (i.e., client ineligible for CIAPAP).
- 19.4 Special circumstance beyond what is indicated above should be discussed with Department of Public Health for prior authorization.
- 19.5 These funds cannot be used for any of the following:
 - To purchase clothing
 - Funeral or burial expenses
 - Transportation of the deceased

- To pay to subsidize routine or ongoing needs related to utilities, rent, meals, cleaning supplies and personal hygiene items.
- To pay for credit checks for Section 8 housing assistance
- To pay for costs at an emergency shelter
- To pay for drivers' licenses, car registrations or automobiles
- Moving expenses and/or basic furnishings
- Household appliances, pet foods or products
- Support employment, vocational rehabilitation, or
employment readiness
- Personal property taxes
- Mortgage payments

SECTION III

ADMINISTRATIVE POLICIES AND PROCEDURES

20.0 Recruitment of New Staff

- 20.1 When a contractor becomes aware of a vacant Title II-funded position, the agency's executive director or designee must inform the Department of Public Health (DPH), Health Care & Support Services (HCSS) Unit staff within one week of the occurrence. Notification must be in writing and directed to the HCSS Contract Manager and copied to the Quality Assurance Nurse Consultant.
- 20.2 Notification must include a brief interim plan to assure that continuity of care for Title II-eligible clients will not be interrupted.
- 20.3 The agency should follow their internal policy for recruiting staff.
- 20.4 The agency is required to complete and submit the Staff Approval Form for New Hires along with the résumés of the top three candidates with an accompanying letter indicating the preferred candidate and the justification for hiring the candidate. The letter should include any plans for training and supervision of the new hire, if applicable.
 - a. All new professional level staff such as Case Managers, Mental Health Workers, etc., must have a minimum of a Bachelor's degree in Social Work, Human Services, Public Health or a related field. Equivalent course work and/or experience may be submitted for consideration.
 - b. This procedure applies to all full-time or part-time staff members who provide HIV or HIV-related services to Ryan White Title II-eligible clients (e.g., Case Managers, Program Supervisors, Housing

Coordinators, etc.) This procedure does not apply to clerical or fiscal positions.

- c. Any questions or concerns regarding new hires may be directed to either the agency's DPH Contract Manager, Quality Assurance Nurse Consultant, or to the Supervisor of the Health Care & Support Services Unit. All attempts are made to review the required information within two business days. The DPH HCSS fax number is (860) 509-7853.

20.5 Every effort should be made to prevent staff attrition due to "burnout." Suggestions to prevent burnout are: increase networking opportunities with other peers, support attendance at educational seminars, offer training opportunities at an appropriate level for the Title I or II-funded staff, and offer career mobility for competent staff who have longevity in the Title I or II programs.

20.6 Funds awarded Title II may not be used to pay for professional licensure or to meet program licensure requirements.

21.0 Case Management Trainings

21.1 All new case managers must attend HIV 101, Case Management and Record Keeping educational seminars. Exceptions to this rule may be made in the event of staff illnesses and

when client needs supersede the training. A case manager may only have one excused absence.

- 21.2 Staff must plan to attend the trainings during their first year of employment (providing the trainings are offered).
 - 21.3 Every agency must have an internal orientation curriculum specific to the position.
 - 21.4 It is highly recommended that new employees be assigned a mentor, a current employee with the same job responsibilities, during the orientation period or beyond if necessary.
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22.0 Case Management Case Loads

- 22.1 Each case manager (1 full-time equivalent) is expected to carry a caseload of at least 35-50 clients at a time. This requirement may be modified with the approval of DPH.
 - 22.2 If a case manager begins to experience a client "waiting list," the case manager must report this to the program supervisor and to the Department of Public Health Contract Manager.
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23.0 Supervisor Responsibilities

- 23.1 A program supervisor (PS) and clinical supervisor (CS) should be different persons to avoid conflict of interest.
- 23.2 The program supervisor (PS) must provide administrative supervision on an ongoing basis to Title II-funded staff.
- 23.3 The program supervisor must have access to a clinical supervisor for consultation on issues that may arise, including, but not limited to the following:
- Crisis management;
 - Mental and behavioral health issues;
 - Safety concerns;
 - Boundaries and,
 - Other issues that go beyond the scope of basic case management services.
- 23.4 Supervision may be provided in individual or group settings.
- 23.5 The Program Supervisor must contact the DPH contract manager when issues arise that impact client services (e.g., staff shortages, client waiting lists, etc.)
- 23.6 There should be a written protocol on how to access clinical supervision if needed.
-

24.0 Fiduciary Requirements

- 24.1 Agencies must demonstrate that Title II is used as the payer of last resort.
 - 24.2 Agencies may implement financial caps for discretionary client services.
-

25.0 Communicating Title II Policies to Case Managers

- 25.1 The agency must have a mechanism in place to inform case managers (or other funded Title II staff) of Title II/DPH policies.
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26.0 Confidentiality Issues & Record Retention

- 26.1 The agency must safeguard the clients' right to privacy pursuant to Connecticut General Statutes 19a-581-590 and 592.
 - 26.2 The agency shall not disclose a client's name to another agency/staff member without a release of information form.
 - 26.3 The agency must have a policy for retaining client records, as well as for destroying records that pass the retention date.
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27.0 Data Management & Uniform Reporting System (URS)

Agencies are required to manage client specific and aggregate HIV-related data. Examples of the type of data include, but are not be limited to, the following: client identifiers, demographic information, number of clients served, types of services provided, and the cost of the services provided. This information is used to assure that granted funds are used as intended and to improve service delivery for people living with HIV in Connecticut. The Uniform Reporting System (URS) software records are client specific and automatically generate aggregate HIV-related data reported to State and federal agencies. The software offers password expiration features, inactivity timeouts and concurrent logins. Other features include security schemes of user access, and user display to see who is using the software and when. There are important considerations that need to be followed related to data management.

Goal: Data recorded and reported to the Department of Public Health will be accurate and safeguarded for breach of confidentiality. Efficiency in assessing the needs of people with HIV and health care service delivery to them will improve through the use of URS.

27.1 Handling of Information

27.2 *Storage:* File cabinets and computers with individual client information should be located in an office that is locked. If this is not possible, position the computer screen so that it cannot be read by others or install a device to make sure the screen is readable only by the operator.

27.3 *Retrieval:* Only supervisors and data personnel authorized to work on HIV-related information should have access to the URS software. The URS security scheme allows user menus to be tailored to the user, so

that Add/Delete/Edit functions can be "restricted." Additional "View only" access can be created.

27.4 *Access:* Passwords should be kept confidential and changed frequently. In the URS System Menu under Preferences in URS, set the Days between Password Expirations for a short period. Another utility a System Administrator in URS can use to enhance security is to click on Force Password Change for All Users in the System Menu under Preferences. By clicking on this button, all users will be forced to change their passwords the next time they attempt to log in. The new password cannot be the same as the expired password.

27.5 *Absence from Workstation:* Authorized data entry personnel should log off the program when it is temporarily not being used, and when employees leave the office. URS can be programmed to time out when not in use after just one minute. In the System Menu under Preferences, set the URS System Inactivity Time-Out for 2 or 3 minutes. After upgrading the URS version, the time-out minute default is 0. Users can also set the pc's screensaver to lock the screen with password protection upon a certain length of inactivity.

27.6 *Printing Reports:* When printing reports, always suppress client names; this will enable the software to print out client identifiers only. There are two URS reports:

the printed Connecticut Aggregate Reports, and the electronic file Connecticut Extracts. Both reports do not include client information such as name and address, and need to be sent to the DPH each month for the previous month. Since the electronic file Connecticut Extracts is in zipped format, it is encrypted, and therefore acceptable to email as an attached file to the DPH each month.

27.7 *Data Back Up:* Back up data files on tapes, cartridges or disks whenever possible and ensure that all tapes, cartridges, disks, etc., are locked in a secure setting. Backup disks and cartridges should be stored in a safe, restricted location.

27.8 Confidentiality

27.9 *Unique Identifiers:* The client's files should utilize the uniform client identifier system when data is being reviewed or generated for reporting purposes by outside agencies. (The Department Quality Assurance staff is exempted from this requirement when conducting quality assurance monitoring activities.) The URS software client unique identifier is an automatically generated numbering system. The client ID is the first two letters of the last name, followed by the first two letter of the first name, followed by the birth data (mm/dd/yy) then M or F for gender, then a sequential number if there are duplicate patients.

- 27.10 *Worker Participation:* Have a written confidentiality policy and require employees to sign a *confidentiality agreement*. The contractor must require all employees who are responsible for data management and information within the agency to sign a confidentiality and user agreement. This agreement should be kept on file at the agency and should include issues concerning confidentiality such as who owns the data access security, security of laptop computers when not in use and appropriate computer use.
- 27.11 *Federal Standards:* These policies protect citizens from unlawful disclosure of medical records as they pertain to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Contracting agencies must be HIPAA compliant.
- 27.12 *Data Handling:* The handling of data is the responsibility of the supervisor or data person authorized to handle such critical data. These assurances will establish a system to ensure that a client's right to privacy is protected under the Health Insurance Portability and Accountability Act of 1996. Any contractor or subcontractor shall be liable under this law for disclosing any confidential information. See Appendix A for a sample Employee Confidentiality Agreement.
- 27.13 *Data Access:* Accessibility to confidential information should be granted only to

authorized individuals within the agency and to consortium member agencies listed on the agencies informed consent inter-agency provider agreement forms or the agency release of information form signed by the client. In the URS, users are limited to menu selections based on their assigned security schemes. A security scheme also limits add, edit and delete rights.

27.14 Reporting Requirements

27.15 *Forms Usage:* Agencies will use the required forms issued by their funding source for data management and quarterly reports to the Office of Policy and Management.

27.16 *Confidential Reports:* Hard copy files must be printed with client names suppressed. This means that only the client identifier will be printed. The URS does not generate any report with personal client information. No facsimiles shall be transmitted with client names evident.

27.17 *Standards:* The following standards must be observed when entering required URS data:

a. All fields must be filled in using codes, if applicable.

b. Date of service must be the date client had services (not the date the bill was paid).

c. Type of services must be specified (e.g., for prescription, list name of medication, not "prescription or drug.")

27.18 *Quality Assurance:* Supervisors should conduct quality assurance checks for data in the system and hard copy files at a minimum of a quarterly basis.

27.19 *Office Equipment:* Make sure that computers are turned off at the end of each use to prevent unauthorized access.

27.20 *Client Inactivation:* After six months of absence, the client should be inactivated within the URS software.

a. Print the Active Clients without Encounters Report under Activities.

b. In the Client menu, select the client, then select Status Changes, next select Admission/Discharge, and then select Add a Change of Status, on bottom left. Pick the reason and the data of inactivity.

c. To reopen an inactive client in the client menu, select the client, then select Status Changes, then select Admission/Discharge, and finally select Add a Change of Status on bottom left. Pick Reopen under Change of Status. Though basic client information appears, you must re-enroll the client in any program that he or she participates in.

27.21 Laptop Computers

27.22 *Individual Responsibility:* Laptop computers are the responsibility of the individuals using these computers. During usage, security of the laptop and its contents are the responsibility of the case manager or persons authorized to use the laptop.

27.23 *Tracking laptops:* If laptops are to be used by more than one person in an agency, a sign-up sheet should be used to keep track of the laptops.

27.24 *Security:* Whenever laptops are used outside the office, certain security measures should be taken to ensure privacy of the clients' information.

- *User Security:* Enables the user-level security, which prevents unauthorized access to system setup and security options.

- *Lock Keyboard:* Enables you to specify an amount of time that the computer can remain idle (no keyboard or mouse activity) before the keyboard locks up.

- *Lock Floppy:* Allows a user with a system administration password to disable the floppy-disk drive so that a user with a user password cannot use it. This prevents users from downloading from the computer.

- *Storage:* Whenever laptops are not in use either in the home or the office, they should be kept in a secured storage unit. Vehicles are unacceptable places to store laptop computers.
- *Data:* Data can only be used for the purpose of HIV case management reporting and implementation. The data within the laptops or PCs cannot be used for writing papers or given to unauthorized persons for statistical information.

27.25 Contractors No Longer Funded for HIV/AIDS Services

27.26 Delete URS from network or stand-alone personal computer. After running the appropriate reports, the DPH contractor's System Administrator must send a full URS extract to the DPH after entering data up to the last day of the contract. The System Administrator should delete the URS software from the network or stand-alone pc in order to maintain client confidentiality unless contracted from another entity to report services in URS.

28.0 Required Forms

28.1 Title II-funded agencies are required to use forms developed or endorsed by DPH, Health Care & Support Services Unit (e.g., Client Record forms, DPH Reporting Forms, etc).

29.0 Quality Management

- 29.1 The provider will have written policies for a client Grievance Procedure. The policy will identify the steps a client should follow to file a grievance and state how the grievance will be handled.
- 29.2 The provider will document that clients have been informed of Grievance Procedures.
- 29.3 The provider will have a system in place to review on a regular basis, the types and levels of services provided to clients, to determine the appropriateness of services.
- 29.4 The provider will document service goals and review aggregate information about such goals at least annually. The provider will use this review to enhance program design.
- 29.5 The provider will have a continuous quality improvement process that identifies areas requiring review, develops and implements changes in procedures, and documents the results of the changes.
- 29.6 The provider should consider using client satisfaction surveys as a means of gathering information about the response to and efficacy of services.

Appendix A

Supervisee's Agreement of Confidentiality

I, _____, hereby agree to maintain the confidentiality of my clients and the clients of my fellow supervisees.

I will transport case notes in the following manner:

1. Client Intake Forms for data entry into the URS software;
2. Care Services Forms for data entry into the URS software.

I will respect the confidentiality of individuals to whose records I have been given access. I will observe any ethical restrictions and will abide by applicable laws and policies with respect to access, use, or disclosure of administrative data and information.

I will not give data to persons not authorized to have access to it. I understand that Clifford Beers expressly forbids the disclosure of unpublished administrative data or the distribution of such data in any medium, except as required by my job duties and responsibilities that have been approved in advance. I will not discuss cases with anyone except my supervision group, my site supervisor(s), or person so designated. This restriction includes my family, friends, colleagues, supervisors, faculty, referral sources or administrators.

I will follow control procedures and take reasonable measures to protect the administrative data to which I have been granted access. I will be responsible for the accurate presentation of administrative data and will be responsible for the consequences of any intentional misrepresentation of that data on my part.

My signature indicates that I have read, understand and agree to abide by the terms and conditions of this agreement.

Employee's Name (Please Print)
Employee's Signature

Date

Agency Name