



4. The following are the acceptable forms for documentation of HIV status for ambulatory outpatient medical service providers:
  - ❖ A positive Western Blot laboratory result, which includes the name of the client. (Anonymous test results are not acceptable.)
  - ❖ A **detectible** HIV “viral load” test which includes the name of the client.
  - ❖ A hospital discharge summary that documents HIV positive status.
5. The following are the acceptable forms for documentation of HIV status for all other service providers:
  - ❖ A positive Western Blot laboratory result, which includes the name of the client. (Anonymous test results are not acceptable.)
  - ❖ A **detectible** HIV “viral load” test which includes the name of the client.
  - ❖ A signed diagnosis from a physician, physician’s assistant, or advanced nurse practitioner.
  - ❖ A statement signed by a registered nurse relaying the diagnosis that exists by virtue of having documentation in a medical record.
  - ❖ A hospital discharge summary that documents HIV positive status.
6. Statements signed by social workers and/or other health care professionals not listed above are **not** sufficient to meet the minimum requirements of documentation of HIV status.
7. An anonymous test result may be used for up to sixty (60) days to assist a client. After that time, one of the acceptable forms of documentation of HIV status must be obtained. FOR FEE-FOR SERVICE PROVIDERS: Should the acceptable forms of documentation not be obtained by sixty (60) days, all billed charges for the client would be disallowed after the sixty day grace period.
8. Confirmatory testing is an allowable cost if a Subgrantee needs to confirm a client’s HIV status and other HIV status documentation is missing or unacceptable.
9. When services are provided to affected family members of an HIV-infected person, documentation of the client’s relation to the HIV-infected person should be documented. If the HIV-infected person is a client of the Subgrantee, the HIV-infected person’s documentation of HIV status should be available for review during annual quality compliance reviews.
10. Where services are provided to affected family members of an HIV-infected person whose documentation of HIV status are not available, a signed statement (by the person receiving services) of the HIV status of the infected family member will be deemed as acceptable proof. (This circumstance traditionally occurs when family members are receiving bereavement counseling.) The Subgrantee should complete a waiver request and submit it to The Resource Group for approval.
11. Subgrantees may establish thresholds of documentation that exceed these minimum requirements. However, **no** Subgrantee may establish thresholds of documentation that fail to meet these minimum requirements.

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

DOCUMENTATION OF ELIGIBILITY (SG-04)

EFFECTIVE DATE: November 17, 2006

PURPOSE:

To establish acceptable documentation of identity, income and residency for all funding from The Resource Group.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with the Resource Group to provide services.

**Client Level Data Reporting System** is the data software system designated in the Subgrantee's contract as the vehicle for complying with the client level data reporting requirement. Currently only two systems are approved by The Resource Group. For Houston providers funded under Department of State Health Services Ryan White Part B and State Services, the approved system is the Centralized Patient Care Data Management System (CPCDMS). For all other providers, the approved system is the AIDS Regional Information Evaluation System (ARIES).

POLICY:

Each Subgrantee that receives funding from The Resource Group must obtain and maintain documentation of identity, income, and residency for each client served. The Subgrantee should establish a procedure to obtain and maintain the acceptable documentation of identity, income, and residency that complies with the requirements outlined below. (NOTE: This applies to all funding administered by The Resource Group.)

PROCEDURE:

1. Upon receiving funding from The Resource Group, the Subgrantee must develop procedures to obtain and maintain acceptable documentation of identity, income, and residency for all services that meet or exceed the requirements outlined in this policy.
2. The documentation of identity, income, and residency should always remain within the active client record. The documentation of identity, income, and residency should **never** be archived.
3. Documentation of Identity:
  - A. The following are acceptable forms for documentation of **identity** for all clients:
    - Texas Driver's License

- Texas Identification Card
  - Texas Department of Corrections identification card
  - Employment badge with picture
  - Student ID with picture
  - U.S. immigration documents with picture
  - Credit card with picture
  - Metro picture ID
  - U.S. naturalization, citizenship, passport or other Federal documents with picture
  - Driver's license or identification card issued by another US state
  - A government-issued ID from a country other than the U.S.
  - Birth certificate (cannot be used by married women)
  - Social Security card
  - Medicaid/Medicare card
  - VA ID Card
- B. The following documentation is acceptable only for **undocumented** and/or **homeless** clients:
- Letter on company letterhead from a case manager, social worker, counselor or other professional **from another agency** who has personally provided services to the client
4. Documentation of Income:
- A. The following are the acceptable formats for documentation of **income** for all clients:
- *In the Houston HSDA only*, valid/current copy of "CPCDMS Client Verification" form (for Subgrantees who are NOT the Record Owner)
  - Payroll stub/copy of payroll check/bank statement showing direct payroll deposit
  - Letter from employer on company letterhead indicating weekly or monthly wages
  - Unemployment benefits letter/copy of check
  - IRS 1040 form (tax return)/W2 form/1099 form
  - Social Security award letter
  - VA benefits letter
  - Private disability/pension letter on company letterhead
  - Medicaid letter
  - Child or spousal support order with judge's signature and date
  - Food Stamp award letter (TANF)
- B. The following are the acceptable formats for documentation of income only for clients claiming no income:
- Agency temporary affidavit signed and dated by the client (valid for only 60 days from initial service date)
  - Proof of application for Social Security (valid for 6 months only)
  - Food Stamp award letter (TANF)
  - Client living off savings: bank/investment account statements from 3 consecutive months showing withdrawals for living expenses
  - Client being supported by someone else: statement signed and dated by the supporter, which includes the amount and type of support (room only, room and board, cash assistance, etc.) and the supporter's phone number for verification

- Homeless client: letter on company letterhead from a case manager, social worker, counselor or other professional **from another agency** who has personally provided services to the client.
5. Documentation of Residency:
- A. Acceptable residency documentation: (must be current)
- *In the Houston HSDA only*, valid copy of “CPCDMS Client Verification” form (Agencies Online who are NOT Record Owners)
  - Current lease in the name of the client or listing the client as an occupant
  - Current Property tax documents
  - Current utility/phone/cable bill in the name of the client
  - Current credit card bill in the name of the client
  - Current letter on company letterhead signed by the director of a recognized group home, care home or transitional living facility
  - Any type of current business correspondence with the client’s name and address pre-printed, e.g. auto registration, insurance, bank/brokerage statement, food stamp letter, Social Security letter, Medicaid letter
  - Current pay stub with address
- B. The following documentation is acceptable only for **undocumented** and/or **homeless** clients:
- Agency temporary affidavit signed and dated by the client (valid for only *60 days* from the start of services at the agency)
  - Letter on company letterhead from a case manager, social worker, counselor or other professional **from another agency** who has personally provided services to the client
- C. Residency documentation for minors is required from a parent or guardian with whom the minor resides.
6. Identity need only be established at the onset of service. Income and residency must be updated on an annual basis. However, the client record should be updated within 30 days of the client reporting a change in either income or residency. The changes should also be reflected within the approved client-level data reporting system.
7. Subgrantees may establish thresholds of documentation that exceed these minimum requirements. However, **no** Subgrantee may establish thresholds of documentation that fail to meet these minimum requirements.
8. HIV documentation is outlined in a separate policy (Policy SG-03 DOCUMENTATION OF HIV STATUS).

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

DOCUMENTATION OF THIRD PARTY PAYOR ELIGIBILITY (SG-06)

EFFECTIVE DATE: November 17, 2006

PURPOSE:

To establish requirements for documentation of the process for assessing sources of Third Party Payors (including Medicare and/or Medicaid) for all clients served under funding from The Resource Group.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with the Resource Group to provide services.

POLICY:

Each Subgrantee that receives funding from The Resource Group must assess each client for possible third party payment sources and maintain documentation of Third Party Payors (including Medicare and/or Medicaid) if client is eligible. The Subgrantee should establish a procedure to assess, obtain and maintain the acceptable forms for documentation of client eligibility for third party payment prior to utilization of The Resource Group's funded grants. The procedures must comply with the requirements outlined below. (NOTE: This applies to all funding administered by The Resource Group.)

PROCEDURE:

1. Upon receiving funding from The Resource Group, the Subgrantee must develop a screening procedure for all clients to assess, obtain and maintain the documentation of Third Party Payors eligibility (including Medicare and/or Medicaid) that meet or exceed the requirements outlined in this policy. The screening process should include steps to:
  - a. Determine what employment-based medical insurances each client currently holds;
  - b. Determine what publically-funded medical insurance benefits (e.g. Medicaid) each client receives;
  - c. And, conduct a financial assessment to determine if the client is eligible for any publically-funded medical insurance benefit program.
2. The Subgrantee should incorporate the required screening elements into a written form (i.e. client intake, screening checklist, eligibility screening form, etc.) The documentation of the screening process should be present in each client file.

3. Documentation of eligibility for third party payment should always remain within the active client record. The documentation of eligibility should **never** be archived. Documentation of Third Party Payors should be documented where appropriate in the data collection system (ARIES/CPCDMS).
4. Each client must be reassessed at least annually or when the client's circumstances change.
5. Acceptable documentation to verify third party payor eligibility status:
  - a. Verification of employment, i.e. payroll stub, copy of payroll check, bank statement showing direct payroll deposit, letter from employer on company letterhead indicating weekly or monthly wages no greater than 6 months old (to demonstrate Medicaid/Medicare eligibility status)
  - b. Medicaid/Medicare rejection letter covering the dates of service
  - c. Signed note in patient record showing date and time of call to Medicaid/Medicare (must be done monthly)
  - d. Medifax slips or other automated system (must be done at least monthly)
6. The following Subgrantee systems will be reviewed:
  - a. Policy for the Third Party Payor Process
  - b. Training of staff on Third Party Payor issues.
  - c. Priority list of all publically funded medical insurance benefits held within the caseload or that individual clients are potentially eligible for, plus all employment-based medical insurances held by clients with the agency caseload.
  - d. Enrollment process with clients who are potentially eligible for Medicaid and/or other publically-funded health insurance benefit program(s).
  - e. Establishment of and compliance with Subgrantee system for charging, collecting, and tracking client monies, including insurance co-payments and client contributions to their own medical care whether on a sliding scale of flat fee basis.
  - f. For clinic-based Subgrantees, application for the ability to bill Medicaid, Medicare and Employer-Based Insurance companies, etc.
  - g. For free-standing case management facilities, pursuit of billing for available third party payors for services provided with contracted physicians and other Medicaid-eligible services.
  - h. Subgrantee financial systems to track services, billing and payments from third party payors.
  - i. Application for waivers for low priority third party payors.
  - j. Billing to third party payors
  - k. Charges and collection of client contributions to medical care.
7. If the Subgrantee provides one of the following services, it must apply for the ability to bill Medicaid/ Medicare or other third party payment (to assure that Ryan White is payor of last resort):

***Medicaid/Medicare Reimbursable Service Categories***

Outpatient Ambulatory Medical Care	Oral Health Care
Home Health Care	Substance Abuse Treatment
Mental Health Services	Vision Services
Psychiatry	Transportation

8. If the Subgrantee provides one of the above services, the Subgrantee must establish and maintain a system for charging, collecting, and tracking client monies, including insurance co-payments and client contributions to their own medical care whether on a sliding scale or flat fee basis. This system should include financial systems to track services, billing and payments from third party payers.
9. Services rendered under The Resource Group's funding for days on which a client was eligible for Medicaid, Medicare, or another third party payer will be recouped.
10. Subgrantees must make a reasonable attempt to collect monies, however, services must be provided without regard to ability of the client to pay. Monies owed but not received from the client are not considered uncollected debt. Subgrantees should not track these amounts. Any monies received are considered program income for that month, regardless of when the services were provided.
11. If the Subgrantee provides one of the above services through subcontract with another entity, the subcontracted entity must comply with the expectations of this policy.
12. A Subgrantee may establish thresholds of documentation that exceed these minimum requirements. However, no Subgrantee may establish thresholds of documentation that fail to meet these minimum requirements.
13. Compliance with this policy will be monitored as part of each Subgrantee's annual quality compliance review.

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

SUBGRANTEE EXCHANGE/RELEASE OF INFORMATION (SG-07)

EFFECTIVE DATE: May 17, 2004

PURPOSE:

To establish the criteria required for the exchange and/or release of confidential client information in the course of service provision by a Subgrantee.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with The Resource Group to provide services.

**Confidential Client Information** is any information that might disclose a client's identity including, but not limited to, client name, address, phone number, social security number, or other identifying information.

**Client** is an individual seeking services from a funded Subgrantee. For the purpose of these policies, client includes legal guardians and/or powers of attorneys.

POLICY:

Each Subgrantee that receives funding from The Resource Group must establish a procedure for releasing confidential client information and an Exchange/Release of Information form. This form is designed to document client's informed consent for confidential client information to be disseminated by the Subgrantee and protects the Subgrantee from violating applicable HIV confidentiality laws.

PROCEDURE:

1. Upon receiving funding from the Resource Group, the Subgrantee must develop a policy that covers the exchange/release of confidential client information.
2. The policy should require the Subgrantee staff to obtain the informed written consent of a client prior to releasing or exchanging confidential client information with a third party.
3. The policy should include a provision that allows the Subgrantee to, under emergency conditions such as a life-threatening situation, or when a client's condition precludes the possibility of obtaining written consent, provide pertinent information to the medical personnel responsible for the client's care. The staff member responsible for the release of this information shall enter all pertinent information about the transaction into the client's client record.

4. The policy should also take into account the Subgrantee's requirement to provide information under circumstance involving a court order or subpoena.
5. As part of that policy, the Subgrantee must develop a written consent for the exchange/release of information form that includes the following required elements:
  - Name of agency/agencies to which the information is disclosed
  - General information to be disclosed
  - General purpose of disclosure
  - Signature of client and date the consent was signed
  - Expiration date (no greater than two years from date of original signed consent)
6. When client information is disclosed, the client record must contain the following:
  - The consent to release information
  - The actual date the information release
  - The signature of the staff member disclosing the information
7. Clients must be allowed to withdraw their consent to exchange/release information to any individual or organization at any time. This withdraw of permission should be documented within the file.

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

REQUESTS FOR WAIVER (SG-12)

EFFECTIVE DATE: September 1, 2003

PURPOSE:

To establish a uniform method of requesting waivers to provide services outside the scope of a contract or to exceed a limitation to services imposed by a contract.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with the Resource Group to provide services.

POLICY:

Each Subgrantee must request **in advance** a waiver to provide services outside the scope of their contract or to exceed a limitation to services imposed by their contract. NOTE: This applies to all services that are provided on a fee-for-service basis regardless of funding.

PROCEDURE:

1. A Subgrantee must submit a *Request for Waiver* form (attached) to provide services outside the scope of its contract or to exceed a limitation to services imposed on a service category. All waiver requests must be submitted **in advance** of providing the services to be considered for approval via email fax, or mail. Waiver requests will not be approved retroactively unless extenuating circumstances are in evidence.
2. Once received by The Resource Group, the *Request for Waiver* form will be date stamped and forwarded to the Program Development Director for review. (For faxed/emailed requests, the date from the fax machine/email will serve as evidence of date of receipt.)
3. Once a waiver has been reviewed, it will be approved or denied. In some cases, the waiver request may include modifications by the Program Development Director prior to signature.
4. A copy of signed waiver request will be returned to the Subgrantee. The original signed waiver request will be filed in the Subgrantee's grant file.
5. When billing the referenced services, the Subgrantee must attach a copy of the approved *Request for Waiver* form to the appropriate Reimbursement Request as supporting documentation. Failure to submit a copy of the waiver form could result in the units being disallowed.
6. Waiver requests to serve clients outside of a Subgrantee's established HSDA must comply with The Resource Group's policy *SG-17: Requesting to Serve Clients Outside Established HSDA*.

# THE HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.

## REQUEST FOR WAIVER

<b>NAME OF SUBGRANTEE:</b>			
<b>SERVICE:</b>			
<b>CONTRACT NO:</b>		<b>CONTRACT PERIOD:</b>	

**WAIVER REQUEST:**

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(ONE FORM PER CLIENT)

<b>CLIENT 14-CHARACTER CODE:</b>			
<b>EFFECTIVE DATE:</b>		<b>END DATE:</b>	

**PURPOSE OF THE WAIVER:** describe in detail how the requested waiver will enhance **client services**.

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**SUBMITTED BY:**

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

*SUBMIT TO PROGRAM DEVELOPMENT DIRECTOR, THE RESOURCE GROUP*

*FOR THE RESOURCE GROUP'S USE ONLY*

**DENIED**
                 
  **APPROVED**
                 
  **APPROVED WITH MODIFICATIONS BELOW**

**MODIFICATIONS:**

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\_\_\_\_\_  
*PROGRAM DEVELOPMENT DIRECTOR*

\_\_\_\_\_  
*DATE*

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

MEDICAL TRANSPORTATION REQUESTS FOR WAIVER (SG-13)  
(PART D)

EFFECTIVE DATE: June 3, 2008

PURPOSE:

To establish a uniform method of requesting waivers to provide medical transportation services outside the scope of a contract or to exceed a limitation to services imposed by a contract.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with the Resource Group to provide services.

POLICY:

Each Subgrantee must request **in advance** a waiver for approval by the contract Part D Transportation Provider for any services outside the established medical transportation scope of work (core-medical services).

PROCEDURE:

1. Health Case Managers must submit a *Medical Transportation Request for Waiver* form (attached) to the attention of the Outreach Coordinator at AIDS Foundation Houston for any “non-core” transportation request.
2. Core Medical Services are:
  - a. Outpatient/Ambulatory Medical Care
  - b. ADAP
  - c. AIDS pharmaceutical assistance
  - d. Oral Health Care
  - e. Early Intervention Services
  - f. Health Insurance premium/cost sharing assistance
  - g. Home health care
  - h. Hospice
  - i. Home and community based health services
  - j. Mental Health
  - k. Outpatient Substance Abuse
  - l. Medical Case Management
3. Waiver Requests must be submitted by mail or fax no less than 72 hours **in advance** of date of request to be considered for approval.

4. Once received by AIDS Foundation Houston, the *Request for Waiver* form will be date stamped and reviewed by the Outreach Coordinator.
5. Once a waiver has been reviewed, it will be approved or denied. In some cases, the waiver request may include modifications by the Outreach Coordinator prior to signature.
6. Approval or denial will be communicated by the Outreach Coordinator to both the Transportation Specialist and the requesting health case manager (via fax or email)
7. The original waiver request will be filed in the client's service file for review at the time of the annual quality compliance review.
8. No "non-core" Medical Transportation is to be provided without a signed waiver from AFH's Outreach Coordinator.
9. No "non-core" Medical Transportation will be provided on an "emergency" basis.
10. Clients must be in "good standing" with AIDS Foundation Houston for a waiver to be approved. "Good standing" means current and complete paperwork.
11. When billing the referenced services, AIDS Foundation Houston must attach a copy of the approved *Request for Waiver* form to the appropriate Reimbursement Request as supporting documentation. Failure to submit a copy of the waiver form could result in the units being disallowed.

**THE HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
MEDICAL TRANSPORTATION REQUEST FOR WAIVER**

<b>NAME OF SUBGRANTEE:</b>			
<b>SERVICE:</b>			
<b>CONTRACT NO:</b>		<b>CONTRACT PERIOD:</b>	

**WAIVER REQUEST:**

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**(ONE FORM PER CLIENT)**

<b>CLIENT 14-CHARACTER CODE:</b>			
<b>EFFECTIVE DATE:</b>		<b>END DATE:</b>	

**PURPOSE OF THE WAIVER:** describe in detail how the requested waiver will enhance **client services**.

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**SUBMITTED BY:**

\_\_\_\_\_  
*SIGNATURE*

\_\_\_\_\_  
*DATE*

*SUBMIT TO OUTREACH COORDINATOR, AIDS FOUNDATION HOUSTON*

*FOR AIDS FOUNDATION HOUSTON'S USE ONLY*

**DENIED**

**APPROVED**

**APPROVED WITH MODIFICATIONS BELOW**

**MODIFICATIONS:**

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\_\_\_\_\_  
*OUTREACH COORDINATOR*

\_\_\_\_\_  
*DATE*

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.  
SUBGRANTEE GUIDELINES  
POLICY AND PROCEDURE

HEALTH CASE MANAGEMENT SERVICES  
RECONNECTION PROCEDURE FOR OUT-OF-CARE CLIENTS (SG-15)  
(PART D)

EFFECTIVE DATE: April 4, 2007

PURPOSE:

To provide guidelines to govern the process by which health case managers reconnect out-of-care clients into primary medical care service.

DEFINITIONS:

**Subgrantee** is an agency that has entered into a grant agreement with the Resource Group to provide services.

**Health case manager (HCM)** is a staff position at funded Subgrantees that coordinates and monitors activities offered to clients who are actively participating in primary medical care services with the goals of removing barriers and promoting continued participation in primary medical care services.

POLICY:

Each health case manager is expected to assist out-of-care clients to reconnect into primary medical care services when they present for service. Successful reconnection into primary medical care services shall occur within forty-five (45) days of initial contact or health case management services must be terminated. For purposes of this policy, "successful reconnection into primary medical care services" shall be defined as completion of a primary care visit with a primary medical care provider. When it is determined that a client presenting for health case management service is out of care, the health case manager (HCM) shall initiate the following procedure.

PROCEDURE:

1. The HCM will recertify client's eligibility for primary medical care and health case management services. If this process is not completed at initial visit, the HCM will establish follow-up appointments until the process is completed.
2. The HCM will discuss the importance of enrolling and maintaining participation in primary medical care services at the initial and all subsequent appointments. Additionally, the HCM will discuss the following as appropriate:
  - The applicable HIV medical care system
  - Client's readiness to re-enter primary medical care services

- Client’s choice of primary medical care provider
3. The HCM will establish an initial appointment for the client to re-enter primary medical care services.
  4. The HCM will conduct an assessment interview with the client to determine additional short-term needs. The HCM will complete the Interim Client Acuity Assessment Form as documentation of the assessment interview.
  5. The HCM and client will establish a short-term Service Plan. This short-term Service Plan will identify “re-entry into primary medical care services” as the primary goal. The window of completion for re-entry into primary medical care services will be no longer than forty-five (45) days. Subsequent goals will vary according to the HCM assessment and client prerogative.
  6. All referrals and outcomes from short-term Service Plan will be documented in progress notes and the ARIES Referral Tracking module.
  7. The HCM will obtain a consent/release to exchange information with the selected primary medical care provider.
  8. The HCM will follow-up with client and primary medical care provider regarding the client’s compliance with re-entry into primary medical care services. Dependent upon the outcome, the HCM will follow the step outlined in the chart below:

Track A: Client Successfully Re-enters Primary Medical Care Services (PMCS)	Track B: Client Does Not Re-Enter Primary Medical Care Services (PMCS)
<ol style="list-style-type: none"> <li>1. The HCM will document successful completion of referral into PMCS in progress notes and ARIES Referral Tracking module.</li> <li>2. The HCM will establish a follow-up appointment with the client to complete additional required paperwork. (The Interim Client Acuity Assessment Form is valid for no longer than 45 days for a case-managed client.) Completion of a comprehensive assessment must be completed within 30 days of re-entry into PMCS.</li> <li>3. The HCM and client will review and revise the short-term Service Plan to address any additional goals.</li> <li>4. The HCM will assign the client to an appropriate service need level.</li> <li>5. Additional service will be provided in accordance with the established HCM Standards of Care.</li> </ol>	<ol style="list-style-type: none"> <li>1. The HCM will contact the client regarding unsuccessful completion of referral into PMCS. The HCM will document the unsuccessful referral and the reason in progress notes and ARIES Referral Tracking module.</li> <li>2. The HCM and client will reschedule a PMCS appointment. The HCM and client will reassess any barriers to successful completion of referral and address them accordingly.</li> <li>3. The HCM will follow-up with client and primary medical care provider regarding the client’s re-entry into PMCS.</li> <li>4. If the referral is successfully completed, refer to Track A.</li> <li>5. If the referral is not successfully completed, repeat Steps 1 through 3 of Track B.</li> <li>6. At forty-five (45) days, the HCM will inform the client that HCM services must be terminated due to unsuccessful re-entry in PMCS.</li> <li>7. The HCM will document any exceptions in progress notes including a reason for continuing to serve client.</li> </ol>



## RYAN WHITE PART D STANDARDS OF CARE 1.0 HEALTH CASE MANAGEMENT SERVICES

Effective: October 1, 2009

### KEY DEFINITIONS

#### Family-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the pivotal role of the family/caregiver in the lives of clients. It promotes healthy patterns of living and ensures the family/caregiver's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

#### Youth-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the individual strengths and unique physical, emotional, educational, and cultural needs of the youth. It promotes healthy patterns of living and ensures the youth's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

#### Culturally Appropriate Care:

An approach to the provision of service that recognizes, respects, and supports the cultural uniqueness of the client. It includes demonstrated experience and familiarity with the culture and literacy level of the project's target populations.

### THE ROLE OF HEALTH CASE MANAGEMENT IN OUTPATIENT AMBULATORY MEDICAL CARE (OAMC)

Health Case Management consists of actively progressing towards established goals in the support of outpatient ambulatory medical care offered to clients who are enrolled in care. All clients should be enrolled in outpatient ambulatory medical care and working toward compliance with care requirements. By its very nature, health case management can not be provided to clients who are out of care (defined as six months without outpatient ambulatory medical care) unless it is focused on reconnecting clients into care.

Health Case Management includes, but is not limited to, the following:

1. Connecting/Reconnecting clients into Outpatient Ambulatory Medical Care (OAMC);
2. Facilitating the removal of barriers to OAMC (transportation, childcare, etc.);
3. Monitoring of participation in OAMC (appointment compliance, etc.);
4. Educating the client (medication adherence, health care options, community resources, life skills, healthy relationships, etc.);
5. Increasing the client's health literacy in regards to himself/herself and family/significant others;
6. Assisting the client in moving toward compliance with OAMC requirements and increased/maintained stability in living situation;
7. Tracking of the completion of referrals to specialty medical and care-enabling services;

8. Participation in multi-disciplinary team reviews to advocate for client need; and
9. Tracking of performance measures to evidence quality of care.

These activities offer support of outpatient ambulatory medical care by stabilizing factors that can lead to non-compliance with medical care. Furthermore, these activities increase the client's ability to become partners in their own care. Without Health Case Management, clients are less likely to succeed in staying healthy and living in a constructive manner.

#### LICENSING/CREDENTIALING FOR HEALTH CASE MANAGERS

Due to the collocation of services at medical facilities, no special licensing/credentialing will be required for Health Case Managers (HCMs).

#### STANDARDS OF CARE

##### 1.1 Required Consents/Acknowledgements

All clients should be oriented to the service to be provided and have the right to consent/decline that service. Consent to initiate service shall be obtained in writing. Additional consent for sharing information in the AIDS Regional Information and Evaluation System (ARIES) and exchange/release information should also be examined and consent obtained. In addition to the consents, the HCM must evidence that the following have been explained to the infant's parent/guardian: 1) rights and responsibilities of the parent/guardian, 2) the agency's grievance procedure, and 3) information on the nature of confidentiality in a healthcare environment.

Required Consents/Acknowledgements (valid for no more than five years except where otherwise noted) shall be complete and in each client record as evidenced by:

- Each client record shall have a Consent for Services form signed by the client/guardian.
- Each client record shall have an ARIES Consent form signed by the client/guardian to designate whether client information can be shared in the system.
- Each client record shall have an Acknowledgment of Receipt of Client Rights and Responsibilities signed by the client.
- Each client record shall have an Acknowledgement of Receipt of Subgrantee's Grievance Procedure signed by the client.
- Each client record shall have an Acknowledgement of Receipt of Confidentiality signed by the client.
- Each client record shall have appropriate Exchange/Release of Information forms signed by the client/guardian to cover any disclosure of client information. *(Valid for no more than two years.)*
- An agency may set lower expiration thresholds for renewing consents but no higher expiration thresholds.

Either Grantee-approved forms or agency-specific forms (approved in writing by The Resource Group) will be used to document consents and acknowledgement. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

## 1.2 Client Eligibility

All clients shall have a thorough screening to determine eligibility for service when requesting services funded through the Ryan White Treatment and Modernization Act grants. Current and potential medical coverage must be reviewed at this time. All clients without current medical coverage must be assessed at intake for potential eligibility for any public or private third party payer (e.g., Medicaid, Medicare, ADAP, and Veterans Administration). The HCM should assist the client with the application process for any potential third party payer. In addition, the client must participate in a financial review to establish annual gross income per the federal poverty guidelines chart and what monies, if any, the client will be contributing to care.

Required evidence of eligibility process is as follows:

- Client's HIV Status shall be present in the client record in accordance with the published *Documentation of HIV Status (SG-03)* policy.
- Client's identity, income level and residency shall be documented in each client record in accordance with the published *Documentation of Eligibility (SG-04)* policy. Client's income level and residency will be reassessed at least annually.
- Client's Third Party Payer eligibility will be documented in accordance with the published *Documentation of Third Party Payer Eligibility (SG-06)* policy.
- Initiation of application process for potential third party payers documented in client record.

## 1.3 Stage of Illness

The client's CDC Stage of Illness at initiation of care shall be present in ARIES and updated annually thereafter. Compliance shall be evidenced by documentation of Stage of Illness in ARIES.

## 1.4 Intake

At initiation of service, all clients shall have a thorough intake to obtain the necessary information used to provide services. Additionally, the intake provides an opportunity to learn about other community resources/services. Intake must be completed when a client is requesting services for the first time or is recommencing services (i.e. has been out of service greater than six months).

Required evidence of the intake process is as follows:

- Case assignment shall be documented in the client record to establish compliance with acceptable timeframe for start of care.
- Initial health case management contact shall be documented in the client record.
- If successful contact is not made with the client, all subsequent attempts at contact shall be documented in the client record.
- Required Consents/Acknowledgments obtained in accordance with *Standard 1.1*.
- Initial eligibility is verified in accordance with *Standard 1.2*.
- An Intake Form should be completed and present in the client record. Either the ARIES Intake Form or an agency-specific form (approved in writing by The Resource Group) may be used. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

- An Interim Client Acuity Assessment shall be completed and present in the client record. The Interim Client Acuity Assessment is designed to assess the immediate medical needs and other presenting problems of the client at the time he/she presents for service. Either the Interim Client Acuity Assessment form or an agency-specific form (approved in writing by The Resource Group) may be used to document this assessment. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.
- Initial clinical trials and consumer advisory board education performed and documented in client record.
- Evidence the HCM explained, and the client received the following:
  - Client rights and responsibilities
  - Client grievance procedure
  - Information on confidentiality
- An Intake Progress Note shall be completed at initial visit. The progress note shall contain all pertinent information regarding the encounter including, but be not limited to:
  - Description of client;
  - Description of encounter; and
  - Overview of immediate needs identified in Interim Client Assessment and any actions taken to address those needs.

### 1.5 Interim Client Acuity Assessment

The Interim Client Acuity Assessment is performed at initiation/recommencement of services. The focus of the interim assessment is to evaluate the client's immediate medical needs and other presenting problems (including any need for care-enabling services) as presented by the client at the initiation of service. The Interim Client Acuity Assessment should also evaluate client's current participation in outpatient ambulatory medical care and any barriers to outpatient ambulatory medical care.

Based upon the information gathered through the assessment process, the HCM should determine the client's acuity. Acuity is designed to go beyond the expression of need to identify the severity of the need. Severity is determined by concrete concepts such as:

- The difficulty of accessing service;
- The complexity of the systems being accessed; and
- The impact on resources (including the community, the agency, and the HCM).

This determination of acuity should be incorporated into the justification section of the brief assessment and describe contributing factors that lead to the assigned acuity.

The Interim Client Acuity Assessment should incorporate a justification of the assigned acuity level for the client's immediate/presenting needs. Areas where no immediate/presenting needs are expressed should be scored as 1 and can be identified as such (i.e. no immediate/presenting need). An expressed need is scored at 2. This acuity will guide the interaction for the first ninety (90) days until the Comprehensive Client Acuity Assessment is completed.

Either the Interim Client Acuity Assessment form or an agency-specific form (approved in writing by The Resource Group) may be used. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

Information obtained from the initial assessment is used to develop the Initial Individualized Client Care Plan as outlined in *Standard 1.6*.

Required evidence of the comprehensive assessment is as follows:

- An Interim Client Acuity Assessment form or approved alternative form for each client is completed at initiation/recommencement of service and be present in the client record.
- Justification for the assigned acuity levels should thoroughly explain the contributing factors to the HCM's decision.

### 1.6 Initial Individualized Client Care Plan

An Individualized Client Care Plan is a negotiated list of activities that lead to the resolution of identified client objectives. All items on the care plan are agreed upon by both the client and HCM. No item should ever be placed on a care plan without the knowledge and consent of the client.

The initial Individualized Client Care Plan creates a strategy for eliminating the client's presenting needs and ensures the client's connection into outpatient ambulatory medical care. The initial care plan should be manageable and limited in scope to no more than five (5) objectives. The initial care plan should be focused on the following items:

- Ensuring that the client is connected into outpatient ambulatory medical care; and
- The client's immediate/presenting needs.

Required evidence of the initial care plan is as follows:

- An initial Individualized Client Care Plan form or approved alternative form for each client is completed at initiation/recommencement of service and be present in the client record.
- Initial care plan is signed by both the client/caregiver and the HCM.
- Initial care plan limits scope of work in accordance with this standard.

### 1.7 Connection into Outpatient Ambulatory Medical Care

Health Case Management services may be provided to assist a client to connect to outpatient ambulatory medical care. Successful connection into primary care shall occur within sixty (60) days of intake or services must be terminated. The activities that shall occur as part of connection into outpatient ambulatory medical care include, but are not limited to:

- Eligibility screening for outpatient ambulatory medical care;
- Education about the medical care system;
- Selection of appropriate provider (if applicable); and
- Scheduling of initial appointment.

All encounters shall be documented in the client record. Client connection into care documented in client record and evidenced in ARIES. Client closure completed according with standard when client fails to connect with outpatient ambulatory medical care.

### 1.8 Comprehensive Client Acuity Assessment

The Comprehensive Client Acuity Assessment is performed between seventy-five (75) and ninety (90) days of the initiation/recommencement of services. The focus of the comprehensive assessment is to build upon the established relationship between client and HCM to more

thoroughly evaluate the comprehensive medical and supportive needs. The HCM should evaluate all of the identified life areas noting any and all needs within those areas.

Based upon the information gathered, the HCM should assess the client's acuity. Acuity is designed to go beyond the expression of need to identify the severity of the need. Severity is determined by concrete concepts such as:

- the difficulty of accessing service;
- the complexity of the systems being accessed; and
- the impact on resources (including the community, the agency, and the HCM).

The Comprehensive Client Acuity Assessment should incorporate a justification of the assigned acuity level for the client's immediate/presenting needs. Life areas are scored from 1 to 4 based upon the number and severity of needs. This acuity will guide the interaction between the client and HCM.

Either the Comprehensive Client Acuity Assessment form or an agency-specific form (approved in writing by The Resource Group) may be used. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

Required evidence of the comprehensive assessment is as follows:

- A Comprehensive Client Acuity Assessment form or approved alternative form for each client dated no less than seventy-five (75) and more than ninety (90) days following initiation/recommencement of service and be present in the client record.
- Justification for the assigned acuity levels should thoroughly explain the contributing factors to the HCM's decision.

### 1.9 Client Acuity Reassessment

A Client Acuity Reassessment is required to be completed annually for those clients actively participating in HCM services. Additionally, a client must be reassessed when the HCM wishes to changes the client's level of acuity or when unanticipated events or changes take place in the client's life (e.g., increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system).

The focus of the reassessment is to document changes in the client's comprehensive medical and supportive needs. The reassessment should be used to note improvement or declines in life areas since the last assessment/reassessment was completed. The HCM should evaluate all of the identified life areas identifying any and all changes within those areas. If no changes have occurred in a life area, the HCM can simple note that on the reassessment. If changes have occurred, the changes (whether improvements or declines) should be noted and the acuity adjusted, if necessary.

Required evidence of the reassessment is as follows:

- A Client Acuity Reassessment form or approved alternative form shall be completed at least every twelve months and be present in the client record.

- For any change in the client's service level, a corresponding change in client acuity must first be documented on a completed Client Acuity Reassessment form or approved alternative form.
- Justification for the changed acuity levels should thoroughly explain the contributing factors to the HCM's decision.

#### 1.10 Individualized Care Plan (ICP)

An Individualized Client Care Plan is a negotiated list of activities that lead to the resolution of identified client objectives. All items on the care plan are agreed upon by both the client and HCM. No item should ever be placed on a care plan without the knowledge and consent of the client.

The Individualized Client Care Plan creates a strategy for eliminating the selected needs. The Initial Client Care Plan should be manageable and limited in scope to no more than five (5) objectives. The Care Plan should be reassessed on an as needed basis (PRN) with minimum reassessment every 6 months.

Required evidence of the initial care plan is as follows:

- An initial Individualized Client Care Plan form or approved alternative form for each client is completed at initiation/recommencement of service and be present in the client record.
- Care plan is signed by both the client/caregiver and the HCM.
- Care plan limits scope of work in accordance with this standard.
- Care Plan reassessed at the minimum reassessment of every 6 months.

#### 1.11 Removal of Barriers to Accessing Outpatient Ambulatory Medical Care (OAMC)

- Each client shall be assisted with the removal of any barriers to accessing OAMC.
- Barriers to Access shall include, but are not limited to
  - Medical Transportation
    - Each client's medical transportation needs should be assessed on intake and appropriate referrals made. As appropriate, the transportation service provider will be included in the development/review of a client's psychosocial ICP.
    - Each client's medical transportation service needs should be reassessed annually as evidenced in the progress notes.
    - Health case managers shall assist each client in the coordination of medical transportation based upon need.
  - Childcare /Child-Monitoring
    - Each client's childcare needs shall be assessed on intake and appropriate referrals made. As appropriate, the childcare service provider(s) will be included in the development/review of a client's psychosocial ICP.
    - Each client's childcare service needs shall be reassessed annually as evidenced in the progress notes.
  - Linguistically/Culturally Appropriate Care
    - Each client shall be provided culturally appropriate care as demonstrated by the following:
      - Presence of appropriate translated materials, and/or

- Documentation of provision of translation services.
- Removal of barriers to OAMC shall be documented in the client record.
- All referrals and outcomes to assist in removal of barriers to Primary Care Services shall be documented in progress notes and the ARIES Referral Tracking module in accordance with *Standard 1.15*.

#### 1.12 Monitoring of Participation in Outpatient Ambulatory Medical Care (OAMC)

- Each client's participation in OAMC shall be monitored and assistance provided, as required. A clear justification for the level of intervention should be incorporated in the client's acuity assessment/reassessments.
- Monitoring shall include, but is not limited to:
  - Tracking of missed appointments;
  - Appointment reminders;
  - Medication adherence assessment; and
  - Involvement of Child Protective Services (if applicable).
- All monitoring activities will be evidenced in the progress notes.

#### 1.13 Provision of Client Education

- Each client shall receive appropriate education as needed.
- Monitoring shall include, but be not limited to:
  - Clinical Trials Education
    - All clients shall be provided information about clinical trials that are appropriate to the client's circumstances.
    - Ongoing education regarding the importance of clinical trials and any new clinical trials available shall occur at a minimum of every six months. This education shall be documented in the client's record.
  - Consumer Advisory Board Education
    - All clients shall be provided with education on their eligibility to participate in the agency-level Consumer Advisory Board. This education shall be documented in the progress notes.
    - Ongoing education regarding the importance of participation in the agency-level Consumer Advisory Board shall occur at a minimum of every six months.
    - Clients who participate in agency-level Consumer Advisory Boards shall be informed of membership drives for the Project-Wide Consumer Advisory Board.
  - Safer sex, partner notification, and partner elicitation education
  - Life skills and health relationships
  - Disclosure of status
- A description of all client education shall be documented as part of the progress notes. Whenever possible, client education shall also be documented on the Client Education Tracking form or approved alternative form.

#### 1.14 Increasing Health Literacy

Healthy People 2010 defines health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make

appropriate health decisions.” These are the skills that all people need to, for instance, find their way to the right place in a hospital, fill out medical and insurance forms, communicate effectively with healthcare providers and inform healthcare provider when they do not understand when is being explained.

HCM should work with the client to determine his/her level of health literacy. HCM should work proactively to increase the client’s ability to advocate and express his/her needs within the health care environment.

#### 1.15 Increased/Maintained Compliance with Outpatient Ambulatory Medical Care (OAMC)/Stability in Living Situation

HCMs will assist non-compliant clients increase/maintain compliance with OAMC requirements. HCMs accomplish this through stabilizing factors that can lead to non-compliance with medical care. These goals will be evidenced through, but not limited to the following:

- Education regarding OAMC requirements;
- Education regarding the importance of compliance with OAMC requirements
- Monitoring of stability in the client’s living situation; and
- Provision of proactive assistance to increase/maintain stability of living situation, as needed.

#### 1.16 Tracking of Referrals to Specialty Medical and Care-Enabling Services.

Each client shall be assisted with eligibility and referrals to specialty medical and care-enabling services, including but not limited to: Oral Health Care, Psychiatry/Mental Health, Substance Abuse, Nutritional Assessment, Vision Care, Wellness Services, Developmental Assessment (if applicable), and other care-enabling services (as indicated by client need). Each client referral to specialty care and care-enabling services and its outcome shall be tracked by the health case manager through ARIES and the progress notes.

- Referral Tracking Module in ARIES
  - Each client referral shall include the following: referral date, program responsible for the referral, primary and secondary service categories, agency referred to, targeted or actual appointment date, follow-up date, and specific reason for referral (if applicable)
  - Each client referral shall have a documented outcome that includes the following: outcome date, one of the designated outcomes (kept appointment, no show, rescheduled appointment), and any applicable notes to justify the outcome.
  - Each client referral shall be documented within the progress notes as part of the record of the client encounter.
- Each client referral shall have an outcome noted in ARIES no longer than 90 days following the initiation of referral. All exceptions to this window shall be noted in the applicable notes in the ARIES Referral Module and the progress notes.

#### 1.17 Multidisciplinary Team (MDT) Review

Each client’s case shall be reviewed as a part of a multidisciplinary team meeting (incorporating providers of medical services, mental health services, substance abuse services, etc) on a routine basis. Each agency shall draft a policy to reflect the method and frequency of MDT review. At a minimum, each agency’s policy should reflect a process of reviewing clients who are scheduled

for upcoming appointments and clients who experience a triggering event. Triggering events include, but are not limited to, change in physical or mental health, hospitalization, or destabilization of living environment.

Each agency shall adopt a policy that ensures a formal method of delivering information regarding any appropriate items identified at clinical appointments to the health case manager.

#### 1.18 Provision of Home Visit

The review of a client's living environment is an important aspect of assessing the client's overall situation. Therefore, home visits are encouraged, as appropriate. Clients should have the ability to request that an alternative location be used if disclosure issues exist in the home environment. Prior to closure of "lost to follow-up" clients, a home visit is strongly encouraged.

#### 1.19 Progress Notes

Documentation of all health case management activities for the client and/or family/caregivers, including but not limited to, all contacts and attempted contacts with or on behalf of the client and/or family/caregivers are present in client record. Progress notes should include the following:

- A Data Section that describes in an objective manner the interaction between client and HCM;
- A Goal Section that describes the goals that are to be addressed;
- A Plan Section that outlines the HCM's follow-up actions;
- Duration of encounter; and
- Signature of health case manager.

#### 1.20 Four Acuity Levels of Health Case Management:

Client interaction is guided by the acuity level of the client as determined by the approved acuity assessment system.

##### *Intensive Health Case Management*

- Intensive is defined as:
  - Severe: child/family resistance hinders process; non-compliance, depressed, no family support.
  - Extreme: HCM involvement beyond severe; legal CPS intervention.
- Intensive clients will require regular interaction in the range of weekly to bi-weekly.

##### *Intermediate Health Case Management*

- Intermediate is defined as:
  - Moderate: makes most contacts for follow through; child/family unable to complete tasks, limited coping skills; limited family support
- Intermediate clients will require regular interaction in the range of bi-weekly to monthly.

##### *Limited Health Case Management*

- Limited is defined as:

- Minimal: elimination of initial barriers to care, some assistance necessary for follow through; coping skills evident, information sharing; brief contact, agency referral;
- Limited clients will require infrequent interaction in the range of bi-monthly to quarterly.

#### *Clinical Support Health Case Management*

- Clinical Support is defined as
  - Not requiring ongoing health case management, able to follow through
- HCM should assist as needed (PRN)
- HCM may wish to open file if one does not already exist.
- Unless needs arises to increase acuity, client should not be actively case-managed.

#### 1.21 Client Contact

Contact between client and HCM should correspond with the established acuity and care plan. However at a minimum, the HCM should interact with the client at each clinical visit.

#### 1.22 Client Closure

Clients who have achieved stability, accomplished their objective, or dropped out of care should be closed. HCM should proactively discuss the goal of closure with clients from initiation of services. Prior to closure, the HCM should staff the case with his/her supervisor. When a client is closed, the HCM will complete the Houston Health Case Management Closure Summary form.

The following are established reasons for closure:

- Death
- Lost to Follow Up
- Out of Care (six months without outpatient ambulatory medical care)
- Patient Request
- If closure does not fall in an established category, the reason should be noted and explained.

#### 1.23 Reconnection into Outpatient Ambulatory Medical Care (OAMC)

Health Case Management services may be provided to assist a client to reconnect to Outpatient ambulatory medical care. Reconnection to OAMC should be completed in accordance with The Resource Group's revised policy - SG-15 HCMS Reconnection Procedure for Out-Of-Care Clients (Revised 090803). Successful reconnection into primary care shall occur within sixty (60) days of initial contact or services must be terminated.

#### 1.24 Data Entry

Per contract, all required data shall be entered in ARIES within five (5) days of encounter. Data entry shall accurately reflect the information documented in the client record (including the most current client level data, all applicable health indicators as well as dates and duration of encounter).

#### 1.25 Tracking of Performance Measures

Each client's health indicators (CD4, viral loads, pap smears, etc.) shall be appropriately tracked and entered into ARIES. Health indicators shall be amended as necessary to comply with the expectations of funding sources and The Resource Group. When health indicators are

amended, an implementation process shall be established to allow agency's appropriate time (when available) to comply with the amendment. When the agency has a question about whether a health indicator should be entered, a written communication should be sent to The Resource Group's Data/IT Manager via email for clarification.

## ADMINISTRATIVE STANDARDS OF CARE

### 2.1 Supervision/Case Review

The supervisor shall document case review in the record, as appropriate. At a minimum, supervisor should be consulted prior to:

- Closing a client;
- Initiation of legal intervention (APS, CPS, etc.); and
- Other actions as outlined by Subgrantee policy.

Required evidence of supervision/case review is as follows:

- The supervisor shall document supervision of health case managers in writing
- The exact manner of documentation will be left to the supervisor
- Documentation must be available for review at quality compliance reviews.

### 2.2 Review of Standards of Care

Review of the Standards of Care for Health Case Management Services shall occur on an annual basis and revisions will be implemented in August of each year. Required changes from HRSA shall be implemented within thirty (30) days of receipt.

### 2.3 Implementation of New/Revised Forms

When a form is added or revised, it should be completed at the client's next scheduled appointment (after the published effective date). It is not required to schedule client appointments for the sole purpose of implement new or revised forms.



RYAN WHITE PART D  
STANDARDS OF CARE I.1  
SPECIALTY HEALTH CASE MANAGEMENT SERVICES:  
EXPECTANT MOTHERS

Effective: September 1, 2009

KEY DEFINITIONS

Family-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the pivotal role of the family/caregiver in the lives of clients. It promotes healthy patterns of living and ensures the family/caregiver's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

Youth-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the individual strengths and unique physical, emotional, educational, and cultural needs of the youth. It promotes healthy patterns of living and ensures the youth's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

Culturally Appropriate Care:

An approach to the provision of service that recognizes, respects, and supports the cultural uniqueness of the client. It includes demonstrated experience and familiarity with the culture and literacy level of the project's target populations.

THE ROLE OF HEALTH CASE MANAGEMENT IN REDUCING MOTHER-TO-CHILD TRANSMISSION

Specialty Health Case Management for Expectant Mothers consists of coordinating and monitoring activities offered to women to reduce the risk of mother-to-child transmission and increase the overall health of mother and child throughout the pregnancy. All clients should be enrolled in medical care during and after their pregnancy and working toward compliance with care requirements. If not already in care, the clients should be assisted in enrolling in ongoing medical care and encouraged to maintain compliance with care requirements after delivery. Clients should be educated on the process of monitoring the infant's infection status after delivery and its importance. Finally, clients should also be assisted in establishing proper pediatric care for the infant.

Health Case Management includes, but is not limited to, the following:

1. Connecting/Reconnecting clients into Outpatient Ambulatory Medical Care (OAMC);
2. Facilitating the removal of barriers to OAMC (transportation, childcare, etc.);
3. Monitoring of participation in OAMC (appointment compliance, etc.);
4. Educating the client (medication adherence, health care options, community resources, life skills, healthy relationships, etc.);
5. Increasing the client's health literacy in regards to himself/herself and family/significant others;
6. Tracking of the completion of referrals to specialty medical and supportive services;
7. Participation in multidisciplinary team reviews to advocate for client need; and
8. Tracking of health indicators to evidence quality of care.

These activities offer direct support of the goals of reducing the risk of mother-to-child transmission and ensuring that the client and her infant are connected to stable medical care. Furthermore, these activities help to ensure the client is in a place where she can be compliant with these goals. Without Health Case Management, clients are less likely to succeed in staying healthy and living in a constructive manner.

## LICENSING/CREDENTIALING FOR HEALTH CASE MANAGERS

Due to the collocation of services at medical facilities, no special licensing/credentialing will be required for Health Case Managers (HCMs).

### SERVICE PROVISION STANDARDS OF CARE

#### 1.1 Required Consents/Acknowledgements

All clients should be oriented to the service to be provided and have the right to consent/decline that service. Consent to initiate service shall be obtained in writing. Additional consent for sharing information in the AIDS Regional Information and Evaluation System (ARIES) and exchange/release information should also be examined and consent obtained. In addition to the consents, the HCM must evidence that the following have been explained to the infant's parent/guardian: 1) rights and responsibilities of the parent/guardian, 2) the agency's grievance procedure, and 3) information on the nature of confidentiality in a healthcare environment.

Required Consents/Acknowledgements (valid for no more than five years except where otherwise noted) shall be complete and in each client record as evidenced by:

- Each client record shall have a Consent for Services form signed by the client/guardian.
- Each client record shall have an ARIES Consent form signed by the client/guardian to designate whether client information can be shared in the system.
- Each client record shall have an Acknowledgment of Receipt of Client Rights and Responsibilities signed by the client/guardian.
- Each client record shall have an Acknowledgement of Receipt of Subgrantee's Grievance Procedure signed by the client/guardian.
- Each client record shall have an Acknowledgement of Receipt of Confidentiality signed by the client/guardian.
- Each client record shall have appropriate Exchange/Release of Information forms signed by the client/guardian to cover any disclosure of client information. (*Valid for no more than two years.*)
- An agency may set lower expiration thresholds for renewing consents but no higher expiration thresholds.

Either Grantee-approved forms or agency-specific forms (approved in writing by The Resource Group) will be used to document consents and acknowledgement. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

#### 1.2 Client Eligibility

All clients shall have a thorough screening to determine eligibility for service when requesting services funded through the Ryan White Treatment and Modernization Act grants. Current and potential medical coverage must be reviewed at this time. All clients without current medical coverage must be

assessed at intake for potential eligibility for any public or private third party payer (e.g., Medicaid, Medicare, ADAP, and Veterans Administration). The HCM should assist the client with the application process for any potential third party payer. In addition, the client must participate in a financial review to establish annual gross income per the federal poverty guidelines chart and what monies, if any, the client will be contributing to care.

Required evidence of eligibility process is as follows:

- Client's HIV Status shall be present in the client record in accordance with the published *Documentation of HIV Status (SG-03)* policy.
- Client's identity, income level and residency shall be documented in each client record in accordance with the published *Documentation of Eligibility (SG-04)* policy.
- Client's Third Party Payer eligibility will be documented in accordance with the published *Documentation of Third Party Payer Eligibility (SG-06)* policy.
- Initiation of application process for potential third party payers documented in client record.

### 1.3 Stage of Illness

The client's CDC Stage of Illness at initiation of care shall be present in ARIES and updated, as applicable. Compliance shall be evidenced by documentation of Stage of Illness in ARIES.

### 1.4 Intake

At initiation of service, all clients shall have a thorough intake to obtain the necessary information used to provide services. Additionally, the intake provides an opportunity to learn about other community resources/services. Intake must be completed when a client is requesting services for the first time or is recommencing services (i.e. has been out of service greater than six months).

Required evidence of the intake process is as follows:

- Case assignment shall be documented in the client record to establish compliance with acceptable timeframe for start of care.
- Initial health case management contact shall be documented in the client record.
- If successful contact is not made with the client, all subsequent attempts at contact shall be documented in the client record.
- Required Consents/Acknowledgments obtained in accordance with *Standard 1.1*.
- Initial eligibility is verified in accordance with *Standard 1.2*.
- An Intake Form should be completed and present in the client record. Either the ARIES Intake Form or an agency-specific form (approved in writing by The Resource Group) will be used. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.
- Initiation of the Brief Client Acuity Assessment shall occur at the intake in accordance with *Standard 1.5*.
- Clinical trials and consumer advisory board education provided to client and documented in client record in accordance with *Standard 1.11*.
- An Intake Progress Note shall be completed at initial visit. The progress note shall contain all pertinent information regarding the encounter including, but be not limited to:
  - Description of client;
  - Description of encounter; and
  - Overview of immediate needs identified in Brief Client Acuity Assessment and any actions taken to address those needs.

### 1.5 Brief Client Acuity Assessment

The Brief Client Acuity Assessment is initiated at the intake appointment. The brief assessment is a thorough evaluation of the client's medical needs (including any need for care-enabling services) as presented by the parent/guardian at the initiation of service. Finally, the brief assessment evaluates any barriers to compliance with OAMC so they may be resolved.

Brief assessments should be updated on an as needed (PRN) basis. At a minimum, a client must be reassessed when the HCM wishes to change level of interaction with the client or when unanticipated events or changes take place in the client's life or the parent/guardian's circumstances (e.g., increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system).

Based upon the information gathered through the assessment process, the HCM should determine the client's acuity. Acuity is designed to go beyond the expression of need to identify the severity of the need. Severity is determined by concrete concepts such as

- The difficulty of accessing service;
- The complexity of the systems being accessed; and
- The impact on resources (including the community, the agency, and the HCM).

This determination of acuity should be incorporated into the justification section of the brief assessment and describe contributing factors that lead to the assigned acuity.

Either the Brief Client Acuity Assessment form or an agency-specific form (approved in writing by The Resource Group) will be used to document the assessment of need and the determination of acuity. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

Information obtained from the brief assessment is used to develop the Individualized Client Care Plan as outlined in *Standard 1.6*.

Required evidence of the comprehensive assessment is as follows:

- A Brief Client Acuity Assessment form or approved alternative form for each infant is completed within five (5) days of intake and be present in the client record.
- Justification for the assigned acuity levels should thoroughly explain the contributing factors to the HCM's decision.
- Reassessment is completed when the acuity level has been changed or when unanticipated events or changes take place in the infant's or the parent/guardian's circumstances.

### 1.6 Connection into Outpatient Ambulatory Medical Care (OAMC)

Health Case Management services may be provided to assist a client to connect to ongoing outpatient ambulatory medical care. Successful connection into OAMC shall occur within sixty (60) days of intake. The activities that shall occur as part of connection into outpatient ambulatory medical care include, but are not limited to:

- Eligibility screening for outpatient ambulatory medical care;
- Education about the Medical Care System;
- Selection of appropriate provider (if applicable); and
- Scheduling of initial appointment.

Due to the nature of this specialty health case management, the HCM may continue to work with the client despite failure to connect into client into OAMC within the targeted sixty (60) days.

All encounters shall be documented in the client record. Client connection into care documented in client record and evidenced in ARIES.

### 1.7 Individualized Care Plan (ICP)

An Individualized Client Care Plan is a negotiated list of actions that lead to the resolution of identified client objectives. All items on the care plan are agreed upon by both the client and HCM. No item should ever be placed on a care plan without the knowledge and consent of the client.

The Individualized Client Care Plan creates a strategy for eliminating the selected needs. The care plan should be manageable and limited in scope to no more than five (5) objectives. The care plan should be completed within five (5) days of initiations of service. The care plan should be updated on an as needed basis (PRN).

Required evidence of the initial care plan is as follows:

- An Individualized Client Care Plan form or approved alternative form for each infant is completed at initiation/recommencement of service and be present in the client record.
- Care plan is signed by both the parent/guardian and the HCM.
- Care plan limits scope of work in accordance with this standard.
- Care plan revised/updated on a PRN basis.

### 1.8 Removal of Barriers to Accessing Outpatient Ambulatory Medical Care (OAMC)

- Each client shall be assisted with the removal of any barriers to accessing OAMC.
- Barriers to Access shall include, but are not limited to
  - Medical Transportation
    - Each client's medical transportation needs should be assessed on intake and appropriate referrals made. As appropriate, the transportation service provider will be included in the development/review of a client's psychosocial ICP.
    - Each client's medical transportation service needs should be reassessed annually as evidenced in the progress notes.
    - Health case managers shall assist each client in the coordination of medical transportation based upon need.
  - Childcare /Child-Monitoring
    - Each client's childcare needs shall be assessed on intake and appropriate referrals made. As appropriate, the childcare service provider(s) will be included in the development/review of a client's psychosocial ICP.
    - Each client's childcare service needs shall be reassessed annually as evidenced in the progress notes.
  - Linguistically/Culturally Appropriate Care
    - Each client shall be provided culturally appropriate care as demonstrated by the following:
      - Presence of appropriate translated materials, and/or
      - Documentation of provision of translation services.
- Removal of barriers to OAMC shall be documented in the client record.

- All referrals and outcomes to assist in removal of barriers to Primary Care Services shall be documented in progress notes and the ARIES Referral Tracking module in accordance with *Standard 1.15*.

#### 1.9 Monitoring of Participation in Outpatient Ambulatory Medical Care (OAMC)

- Each client's participation in OAMC shall be monitored and assistance provided based on documented limitations that prohibit the parent/guardian from complying with expectations. Justification for this intervention should be incorporated in the client's acuity assessment/reassessments.
- Monitoring shall include, but is not limited to:
  - Tracking of missed appointments;
  - Appointment reminders;
  - Medication adherence assessment; and
  - Involvement of Child Protective Services (if applicable).
- All monitoring activities will be evidenced in the progress notes.

#### 1.10 Coordination with External Providers

HCM should coordinate his/her activities with external providers including, but not limited to, the client's obstetrician and the primary medical provider. If the client is in ongoing case management services at another agency, HCM should coordinate with that case manager to ensure transparency of service delivery and minimize the duplication of effort. Finally, the HCM should assist mother with obtaining an HIV-specific and regular pediatrician for the child as well as applying Medicaid, WIC, and other services that will need to be utilized after delivery.

#### 1.11 Provision of Client Education

- Each client shall receive appropriate education as needed.
- Monitoring shall include, but be not limited to:
  - Clinical Trials Education
    - All clients shall be provided information about clinical trials that are appropriate to the client's circumstances.
    - Ongoing education regarding the importance of clinical trials and any new clinical trials available shall occur at a minimum of every six months. This education shall be documented in the client's record.
  - Consumer Advisory Board Education
    - All clients shall be provided with education on their eligibility to participate in the agency-level Consumer Advisory Board. This education shall be documented in the progress notes.
    - Ongoing education regarding the importance of participation in the agency-level Consumer Advisory Board shall occur at a minimum of every six months.
    - Clients who participate in agency-level Consumer Advisory Boards shall be informed of membership drives for the Project-Wide Consumer Advisory Board.
  - Safer sex, partner notification, and partner elicitation education
  - Life skills and health relationships
  - Disclosure of status
  - Description of the process of monitoring the infant's infection status and its importance
  - Importance and role of a pediatrician in the infant's care.

- A description of all client education shall be documented as part of the progress notes. Whenever possible, client education shall also be documented on the Client Education Tracking form or approved alternative form.

#### 1.12 Increasing Health Literacy

Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” These are the skills that all people need to, for instance, find their way to the right place in a hospital, fill out medical and insurance forms, communicate effectively with healthcare providers and inform a healthcare provider when they do not understand when is being explained.

HCM should work with the client to determine his/her level of health literacy. HCM should work proactively to increase the client’s ability to advocate and express his/her needs within the health care environment.

#### 1.13 Tracking of Referrals to Specialty Medical and Care-Enabling Services.

Each client shall be assisted with eligibility and referrals to specialty medical care and other care-enabling services (as indicated on the care plan). Each referral to specialty care and care-enabling services and its outcome shall be tracked by the HCM through ARIES and the progress notes.

- Referral Tracking Module in ARIES
  - Each referral shall include the following: referral date, program responsible for the referral, primary and secondary service categories, agency referred to, targeted or actual appointment date, follow-up date, and specific reason for referral (if applicable)
  - Each referral shall have a documented outcome that includes the following: outcome date, one of the designated outcomes (kept appointment, no show, rescheduled appointment), and any applicable notes to justify the outcome.
  - Each referral shall be documented within the progress notes as part of the record of the client encounter.
- Each referral shall have an outcome noted in ARIES no longer than ninety (90) days following the initiation of referral. All exceptions to this window shall be noted in the applicable notes in the ARIES Referral Module and the progress notes.

#### 1.14 Multidisciplinary Team (MDT) Review

Each client’s case shall be reviewed as a part of a multidisciplinary team meeting (incorporating providers of medical services, mental health services, substance abuse services, etc) on a routine basis. Each agency shall draft a policy to reflect the method and frequency of MDT review. At a minimum, each agency’s policy should reflect a process of reviewing clients who are scheduled for upcoming appointments and clients who experience a triggering event. Triggering events include, but are not limited to, change in physical or mental health, hospitalization, or destabilization of living environment.

Each agency shall adopt a policy that ensures a formal method of delivering information regarding any appropriate items identified at clinical appointments to the health case manager.

When applicable, evidence of the input of the obstetrician and the primary medical provider should be evidenced.

### 1.15 Provision of Home Visits

The review of a client's living environment is an important aspect of assessing the client's overall situation. Therefore, home visits are encouraged, as appropriate. Clients should have the ability to request that an alternative location be used if disclosure issues exist in the home environment. Prior to closure of "lost to follow-up" clients, a home visit is strongly encouraged.

### 1.16 Progress Notes

Documentation of all health case management interactions with or on behalf of the client and/or affected family/caregivers, including but not limited to, all contacts and attempted contacts with or on behalf of the client and/or affected family/caregivers is present in client record. Progress notes should include the following:

- A Data Section that describes in an objective manner the interaction between client and HCM;
- A Goal Section that describes the goals that are to be addressed (as applicable);
- A Plan Section that outlines the HCM's follow-up actions;
- Duration of encounter; and
- Signature of health case manager.

### 1.17 Four Acuity Levels of Health Case Management:

Client interaction is guided by the acuity level of the client as determined by the approved acuity assessment system.

#### *Intensive Health Case Management*

- Intensive is defined as:
  - Severe: child/family resistance hinders process; non-compliance, depressed, no family support.
  - Extreme: HCM involvement beyond severe; legal CPS intervention.
- Intensive clients will require regular interaction in the range of daily to weekly.

#### *Intermediate Health Case Management*

- Intermediate is defined as:
  - Moderate: makes most contacts for follow through; child/family unable to complete tasks, limited coping skills; limited family support
- Intermediate clients will require regular interaction in the range of bi-weekly to monthly.

#### *Limited Health Case Management*

- Limited is defined as:
  - Minimal: elimination of initial barriers to care, some assistance necessary for follow through; coping skills evident, information sharing; brief contact, agency referral;
- Limited clients will require infrequent interaction in the range of bi-monthly to quarterly.

#### *Clinical Support Health Case Management*

- Clinical Support is defined as
  - Not requiring ongoing health case management, able to follow through
- HCM should assist as needed (PRN)
- HCM may wish to open file if one does not already exist.
- Unless needs arises to increase acuity, client should not be actively case-managed.

### 1.18 Client Contact

Contact between client and HCM should correspond with the established acuity and care plan. However at a minimum, the HCM should interact with the client at each clinical visit.

### 1.19 Transitioning into Ongoing Health Case Management

When the expectant mother delivers yet has ongoing needs that still need to be addressed, the case should be transitioned from specialty health case management into ongoing health case management. *Ryan White Part D Standards of Care 1.0: Health Case Management* will apply from the date of transitions. For purposes of the standards, the date of transitions will be considered the initiation of services. The Brief Client Acuity Assessment will be considered the equivalent of the Interim Client Acuity Assessment. Therefore the Interim Client Acuity Assessment is not required for clients transitioning to ongoing case management services. Within ninety (90) days of transition date, a Comprehensive Client Acuity Assessment form will be completed. The HCM may completed the comprehensive assessment at any time within the ninety (90) timeframe based upon the established relationship with the client.

The delivered infant's infection status should be monitored by the HCM if not being monitored by health case manager (funded under Part D funds) at another agency. Service should be provided in accordance with *Ryan White Part D Standards of Care 1.2: Specialty Health Case Management for Exposed Infants*.

### 1.20 Client Closure

Expectant mothers should be followed to term. After the delivery, the infants should be followed through the determination of their infection status. If the infant is being followed by another health case manager (funded under Part D) at another agency, the HCM may close the case. If not, the HCM should transition the infant into service in accordance with *Ryan White Part D Standards of Care 1.2: Specialty Health Case Management for Exposed Infants*.

Prior to closure, the HCM should staff the case with his/her supervisor. When a client is closed, the HCM will complete the Houston Health Case Management Closure Summary form.

### 1.22 Data Entry

Per contract, all required data shall be entered in ARIES within five (5) days of encounter. Data entry shall accurately reflect the information documented in the client record (including the most current client level data, all applicable health indicators as well as dates and duration of encounter).

### 1.23 Tracking of Health Indicators

Each client's health indicators (initiation of medication regimen, CD4, viral loads, pap smears, etc.) shall be appropriately tracked and entered into ARIES. Health indicators shall be amended as necessary to comply with established performance measures, the expectations of funding sources and the requirements of The Resource Group. When health indicators are amended, an implementation process shall be established to allow agency's appropriate time (when available) to comply with the amendment.

## ADMINISTRATIVE STANDARDS OF CARE

### 2.1 Supervision/Case Review

The supervisor shall document case review in the record, as appropriate. At a minimum, supervisor should be consulted prior to:

- Closing a client;

- Initiation legal intervention (APS, CPS, etc.); and
- Other actions as outlined by Subgrantee policy.

Required evidence of supervision/case review is as follows:

- The supervisor shall document supervision of health case managers in writing
- The exact manner of documentation will be left to the supervisor
- Documentation must be available for review at quality compliance reviews.

### 2.2 Review of Standards of Care

Review of the Standards of Care for Health Case Management Services shall occur on an annual basis and revisions will be implemented in August of each year. Required changes from HRSA shall be implemented within thirty (30) days of receipt.

### 2.3 Implementation of New/Revised Forms

When a form is added or revised, it should be completed at the client's next scheduled appointment (after the published effective date). It is not required to schedule client appointments for the sole purpose of implement new or revised forms.



## RYAN WHITE PART D STANDARDS OF CARE 1.2

### SPECIALTY HEALTH CASE MANAGEMENT SERVICES: EXPOSED INFANTS

Effective: September 1, 2009

#### KEY DEFINITIONS

##### Family-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the pivotal role of the family/caregiver in the lives of clients. It promotes healthy patterns of living and ensures the family/caregiver's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

##### Youth-Centered Care:

An approach to the provision of service that recognizes, respects, and supports the individual strengths and unique physical, emotional, educational, and cultural needs of the youth. It promotes healthy patterns of living and ensures the youth's participation with medical and psychosocial professionals in decision-making, planning and delivery of care.

##### Culturally Appropriate Care:

An approach to the provision of service that recognizes, respects, and supports the cultural uniqueness of the client. It includes demonstrated experience and familiarity with the culture and literacy level of the project's target populations.

#### THE ROLE OF HEALTH CASE MANAGEMENT IN REDUCING MOTHER-TO-CHILD TRANSMISSION

Specialty Health Case Management for Exposed Infants consists of coordinating and monitoring activities offered to exposed infants and their parents/guardians. The parents/guardians who are HIV-positive should be assisted in enrolling in medical care if not already in care and encouraged to maintain compliance with care requirements. Parents/guardians should also be assisted in establishing proper pediatric care for the infants. Moreover, the infant's infection status should be monitored for potential sero-conversion. Additionally, this type of specialty health case management may be extended to assist exposed infants who are enrolled in clinical trials.

Health Case Management includes, but is not limited to, the following:

1. Connecting/Reconnecting the infant into Pediatric Care and his/her parents/guardians into Outpatient Ambulatory Medical Care (OAMC);
2. Facilitating the removal of barriers to Infection Status Monitoring (ISM);
3. Monitoring the participation in ISM (appointment compliance, etc.);
4. Educating the parent/guardian (medication adherence, health care options, community resources, life skills, healthy relationships, etc.);
5. Increasing the parent/guardian's health literacy in regard to the infant, himself/herself and family/significant others;
6. Tracking of the completion of referrals to specialty medical and care-enabling services;
7. Participation in multidisciplinary team reviews to advocate for client need; and

## 8. Tracking of health indicators to evidence quality of care.

These activities offer direct support of the goals of reducing the risk of mother-to-child transmission and ensuring that the infant is connected to stable pediatric care. Furthermore, these activities help to ensure the parent/guardian is in a place where he/she can be compliant with these goals.

It is understood health case management services provided to an infant must include the parent/guardian for the child. As all information will come from the parent/guardian, the HCM must endeavor to create the same rapport with the parent/guardian as he/she would with an actual client.

### LICENSING/CREDENTIALING FOR HEALTH CASE MANAGERS

Due to the collocation of services at medical facilities, no special licensing/credentialing will be required for Health Case Managers (HCMs).

### SERVICE PROVISION STANDARDS OF CARE

#### 1.1 Required Consents/Acknowledgements

All parents/guardians should be oriented to the service to be provided and have the right to consent/decline that service. Consent to initiate service shall be obtained in writing. Additional consent for sharing information in the AIDS Regional Information and Evaluation System (ARIES) and exchange/release information should also be examined and consent obtained. In addition to the consents, the HCM must evidence that the following have been explained to the infant's parent/guardian: 1) rights and responsibilities of the parent/guardian, 2) the agency's grievance procedure, and 3) information on the nature of confidentiality in a healthcare environment.

Required Consents/Acknowledgements (valid for no more than five years except where otherwise noted) shall be complete and in each client record as evidenced by:

- Each client record shall have a Consent for Services form signed by the parent/guardian.
- Each client record shall have an ARIES Consent form signed by the parent/guardian to designate whether client information can be shared in the system.
- Each client record shall have an Acknowledgment of Receipt of Client Rights and Responsibilities signed by the parent/guardian.
- Each client record shall have an Acknowledgement of Receipt of Subgrantee's Grievance Procedure signed by the parent/guardian.
- Each client record shall have an Acknowledgement of Receipt of Confidentiality signed by the parent/guardian.
- Each client record shall have appropriate Exchange/Release of Information forms signed by the parent/guardian to cover any disclosure of client information. *(Valid for no more than two years.)*
- An agency may set lower expiration thresholds for renewing consents but no higher expiration thresholds.

Either Grantee-approved forms or agency-specific forms (approved in writing by The Resource Group) will be used to document consents and acknowledgement. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

### 1.2 Client Eligibility

All infants shall have a thorough screening to determine eligibility for service when requesting services funded through the Ryan White Treatment and Modernization Act grants. Current and potential medical coverage must be reviewed at this time. Both the infant and his/her parent/guardian without current medical coverage must be assessed at intake for potential eligibility for any public or private third party payer (e.g., Medicaid, Medicare, ADAP, and Veterans Administration). The HCM should assist the client with the application process for any potential third party payer. In addition, his/her parent/guardian must participate in a financial review to establish annual gross income per the federal poverty guidelines chart and what monies, if any, the parent/guardian will be contributing to care.

Required evidence of eligibility process is as follows:

- The birth parent(s) HIV Status shall be used to establish the infant's eligibility for services. HIV status shall be present in the client record in accordance with the published *Documentation of HIV Status (SG-03)* policy. Any exceptions should be clearly noted in the client file.
- Infant's identity and residency as well as the parent/guardian's income level shall be documented in each client record in accordance with the published *Documentation of Eligibility (SG-04)* policy.
- Third Party Payer eligibility will be documented in accordance with the published *Documentation of Third Party Payer Eligibility (SG-06)* policy for both the infant and his/her parent/guardian, if applicable.
- Initiation of application process for potential third party payers documented in client record.

### 1.3 Stage of Illness

The infant's CDC Stage of Illness at initiation of care shall be present in ARIES and updated annually, as applicable. Compliance shall be evidenced by documentation of Stage of Illness in ARIES.

### 1.4 Intake

At initiation of service, all infants shall have a thorough intake to obtain the necessary information used to provide services. Additionally, the intake provides an opportunity to learn about other community resources/services. Intake must be completed when an infant enters services.

Required evidence of the intake process is as follows:

- Case assignment shall be documented in the client record to establish compliance with acceptable timeframe for initiation of service.
- Initial health case management contact shall be documented in the client record.
- If successful contact is not made, all subsequent attempts at contact shall be documented in the client record.
- Required Consents/Acknowledgments obtained in accordance with *Standard 1.1*.
- Initial eligibility is verified in accordance with *Standard 1.2*.

- An Intake Form should be completed and present in the client record. Either the ARIES Intake Form or an agency-specific form (approved in writing by The Resource Group) will be used. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.
- Initiation of the Brief Client Acuity Assessment shall occur at the intake in accordance with *Standard 1.5*.
- Clinical trials and consumer advisory board education provided to parent/guardian shall be documented in client record.
- An Intake Progress Note shall be completed at initial visit. The progress note shall contain all pertinent information regarding the encounter including, but be not limited to:
  - Description of infant;
  - Description of encounter; and
  - Overview of immediate needs identified in Brief Client Assessment and any actions taken to address those needs.

### 1.5 Brief Client Acuity Assessment

The Brief Client Acuity Assessment is initiated at the intake appointment. The brief assessment is a thorough evaluation of the infant's medical needs (including any need for care-enabling services) as presented by the parent/guardian at the initiation of service. This assessment should evaluate the parent/guardian's needs and their impact on the infant (including a determination of the parent/guardian's current participation in outpatient ambulatory medical care). Finally, the brief assessment evaluates any barriers to compliance with ISM so they may be resolved.

Brief assessments should be updated on an as needed (PRN) basis. At a minimum, a client must be reassessed when the HCM wishes to change level of interaction with the infant or when unanticipated events or changes take place in the infant's life or the parent/guardian's circumstances (e.g., increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system).

Based upon the information gathered through the assessment process, the HCM should determine the infant's acuity. Acuity is designed to go beyond the expression of need to identify the severity of the need. Severity is determined by concrete concepts such as:

- The difficulty of accessing service;
- The complexity of the systems being accessed; and
- The impact on resources (including the community, the agency, and the HCM).

This determination of acuity should be incorporated into the justification section of the brief assessment and describe contributing factors that lead to the assigned acuity.

Either the Brief Client Acuity Assessment form or an agency-specific form (approved in writing by The Resource Group) will be used to document the assessment of need and the determination of acuity. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms. Agency-specific forms must, at a minimum, meet all requirements set forth in the Grantee-approved forms.

Information obtained from the brief assessment is used to develop the Individualized Client Care Plan as outlined in *Standard 1.6*.

Required evidence of the comprehensive assessment is as follows:

- A Brief Client Acuity Assessment form or approved alternative form for each infant is completed within five (5) days of intake and be present in the client record.
- Justification for the assigned acuity levels should thoroughly explain the contributing factors to the HCM's decision.
- Reassessment is completed when the acuity level has been changed or when unanticipated events or changes take place in the infant's or the parent/guardian's circumstances.

#### 1.6 Connection into Pediatric Care/Outpatient Ambulatory Medical Care (OAMC)

Health Case Management services may be provided to assist infant to connect to ongoing pediatric care. Additionally if the parent/guardian is HIV-positive and not in medical care, the HCM should work with him/her to connect him/her into outpatient ambulatory medical care. Successful connection into pediatric care/OAMC shall occur within sixty (60) days of intake. The activities that shall occur as part of connection into outpatient ambulatory medical care include, but are not limited to:

- Eligibility screening for outpatient ambulatory medical care;
- Education about the Medical Care System;
- Selection of appropriate provider (if applicable); and
- Scheduling of initial appointment.

All encounters shall be documented in the client record. Client connection into care will be documented in client record and evidenced in ARIES. Due to the nature of this specialty health case management, the HCM may continue to work with the infant despite failure to connect into pediatric care within the targeted sixty (60) days.

#### 1.7 Individualized Care Plan (ICP)

An Individualized Client Care Plan is a negotiated list of actions that lead to the resolution of identified client objectives. All items on the care plan are agreed upon by both the parent/guardian and HCM. No item should ever be placed on a care plan without the knowledge and consent of the parent/guardian.

The Individualized Client Care Plan creates a strategy for eliminating the selected needs. The care plan should manageable and limited in scope to no more than five (5) objectives. The care plan should be completed within five (5) days of initiation of service. The care plan should be updated on an as needed basis (PRN).

Required evidence of the initial care plan is as follows:

- An Individualized Client Care Plan form or approved alternative form for each infant is completed at initiation/recommencement of service and be present in the client record.
- Care plan is signed by both the parent/guardian and the HCM.
- Care plan limits scope of work in accordance with this standard.
- Care plan revised/updated on a PRN basis.

#### 1.8 Removal of Barriers to Compliance with Infection Status Monitoring (ISM)

- Each infant and his/her parent/guardian shall be assisted with the removal of any barriers to compliance with Infection Status Monitoring.
- Barriers to Access shall include, but are not limited to:
  - Medical Transportation

- Each infant's medical transportation needs should be assessed on intake and appropriate referrals made.
- Health case managers shall assist the parent/guardian in the coordination of medical transportation based on documented limitations that prohibit the parent/guardian from independently accessing service.
- Childcare /Child-Monitoring
  - Each parent/guardian's childcare needs shall be assessed on intake and appropriate referrals made.
- Linguistically/Culturally Appropriate Care
  - Each parent/guardian shall be provided culturally appropriate care as demonstrated by the following:
    - Presence of appropriate translated materials, and/or
    - Documentation of provision of translation services.
- Removal of barriers to ISM shall be documented in the client record.
- All referrals and outcomes to assist in removal of barriers to ISM shall be documented in progress notes and the ARIES Referral Tracking module in accordance with *Standard 1.15*.

#### 1.9 Monitoring of Participation in Infection Status Monitoring (ISM)

- Each infant's participation in ISM shall be monitored and assistance provided based on documented limitations that prohibit the parent/guardian from complying with expectations. Justification for this intervention should be incorporated in the infant's acuity assessment/reassessments.
- Monitoring shall include, but is not limited to:
  - Tracking of missed appointments;
  - Appointment reminders;
  - Medication adherence assessment; and
  - Involvement of Child Protective Services (if applicable).
- All monitoring activities will be evidenced in the progress notes.

#### 1.10 Coordination with External Providers

HCM should coordinate his/her activities with external providers including, but not limited to, the infant's established pediatricians. Additionally if the parent/guardian is in case management services at another agency, the HCM should coordinate with that case manager to ensure transparency of service delivery and minimize the duplication of effort.

#### 1.11 Provision of Client Education

- Each parent/guardian shall receive appropriate education as needed.
- Education shall include, but is not limited to:
  - Clinical Trials Education
    - All parent/guardians shall be provided information about clinical trials that are appropriate to the infant's circumstances.
    - Ongoing education regarding the importance of clinical trials and any new clinical trials available shall occur at a minimum of every six months. This education shall be documented in the client's record.
  - Consumer Advisory Board Education

- All parent/guardians shall be provided with education on their eligibility to participate in the agency-level Consumer Advisory Board. This education shall be documented in the progress notes.
- Ongoing education regarding the importance of participation in the agency-level Consumer Advisory Board shall occur at a minimum of every six months.
- Parent/guardians who participate in agency-level Consumer Advisory Boards shall be informed of membership drives for the Project-Wide Consumer Advisory Board.
- Safer sex, partner notification, and partner elicitation education
- Life skills and health relationships
- Disclosure of status
- Importance and role of a pediatrician in the infant's care.
- A description of all client education shall be documented as part of the progress notes. Whenever possible, client education shall also be documented on the Client Education Tracking form or approved alternative form.

#### 1.12 Increasing Health Literacy

Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” These are the skills that all people need to, for instance, find their way to the right place in a hospital, fill out medical and insurance forms, communicate effectively with healthcare providers and inform a healthcare provider when they do not understand what is being explained.

HCM should work with the parent/guardian to determine his/her level of health literacy. HCM should work proactively to increase the parent/guardian's ability to advocate and express the needs of the infant within the health care environment.

#### 1.13 Tracking of Referrals to Specialty Medical and Care-Enabling Services.

Each parent/guardian shall be assisted with eligibility and referrals to specialty medical care and other care-enabling services (as indicated on the care plan). Each referral to specialty care and care-enabling services and its outcome shall be tracked by the HCM through ARIES and the progress notes.

- Referral Tracking Module in ARIES
  - Each referral shall include the following: referral date, program responsible for the referral, primary and secondary service categories, agency referred to, targeted or actual appointment date, follow-up date, and specific reason for referral (if applicable)
  - Each referral shall have a documented outcome that includes the following: outcome date, one of the designated outcomes (kept appointment, no show, rescheduled appointment), and any applicable notes to justify the outcome.
  - Each referral shall be documented within the progress notes as part of the record of the client encounter.
- Each referral shall have an outcome noted in ARIES no longer than ninety (90) days following the initiation of referral. All exceptions to this window shall be noted in the applicable notes in the ARIES Referral Module and the progress notes.

#### 1.14 Multidisciplinary Team (MDT) Review

Each infant's case shall be reviewed as a part of a multidisciplinary team meeting (incorporating providers of medical services, external providers, etc) on a routine basis. Each agency shall draft

a policy to reflect the method and frequency of MDT review. At a minimum, each agency's policy should reflect a process of reviewing clients who are scheduled for upcoming appointments and clients who experience a triggering event. Triggering events include, but are not limited to, change in physical or mental health, hospitalization, or destabilization of living environment.

Each agency shall adopt a policy that ensures a formal method of delivering information regarding any appropriate items identified at clinical appointments to the health case manager.

When applicable, evidence of the input of the pediatricians and the parent/guardian's case manager should be evidenced.

#### 1.15 Provision of Home Visits

The review of an infant's living environment is an important aspect of assessing the client's overall situation. Therefore, home visits are encouraged, as appropriate. Clients should have the ability to request an alternative location be used if disclosure issues exist in the home environment. Prior to closure of "lost to follow-up" clients, a home visit is strongly encouraged.

#### 1.16 Progress Notes

Documentation of all health case management interactions with or on behalf of the client and/or affected family/caregivers, including but not limited to, all contacts and attempted contacts with or on behalf of the client and/or affected family/caregivers shall be present in client record. Progress notes should include the following:

- A Data Section that describes in an objective manner the interaction between client and HCM;
- A Goal Section that describes the goals that are to be addressed (as applicable);
- A Plan Section that outlines the HCM's follow-up actions;
- Duration of encounter; and
- Signature of health case manager.

#### 1.17 Four Acuity Levels of Health Case Management:

Client interaction is guided by the acuity level of the client as determined by the approved acuity assessment system.

##### *Intensive Health Case Management*

- Intensive is defined as:
  - Severe: child/family resistance hinders process; non-compliance, depressed, no family support.
  - Extreme: HCM involvement beyond severe; legal CPS intervention.
- Intensive clients will require regular interaction in the range of weekly to bi-weekly.

##### *Intermediate Health Case Management*

- Intermediate is defined as:
  - Moderate: makes most contacts for follow through; child/family unable to complete tasks, limited coping skills; limited family support
- Intermediate clients will require regular interaction in the range of bi-weekly to monthly.

##### *Limited Health Case Management*

- Limited is defined as:

- Minimal: elimination of initial barriers to care, some assistance necessary for follow through; coping skills evident, information sharing; brief contact, agency referral;
- Limited clients will require infrequent interaction in the range of bi-monthly to quarterly.

#### Clinical Support Health Case Management

- Clinical Support is defined as
  - Not requiring ongoing health case management, able to follow through
- HCM should assist as needed (PRN)
- HCM may wish to open file if one does not already exist.
- Unless needs arise that require an increased acuity, client should not be actively case-managed.

#### 1.18 Client Contact

Contact between client and HCM should correspond with the established acuity and care plan. However, minimum contact threshold have been established for infection status monitoring and clinical trials. For infection status monitoring, the minimum contact should be at: 2-4 weeks, 4-8 weeks, 4-6 months, and 12-18 months.

#### 1.19 Infection Status Determination

The agency should have an established policy regarding what criteria it uses to make the final determination that an infant is negative. At a minimum, two (2) negative PCR tests within six (6) months will be sufficient to evidence that mother-to-child transmission was prevented. The infant may be considered negative. The agency should create a policy that outlines its criteria to determine an infant's status that at least meets the minimum criteria outlined here.

#### 1.20 Transitioning into Ongoing Health Case Management

When an infant is determined to have become HIV-infected, the case should be transitioned from specialty health case management into ongoing health case management. *Ryan White Part D Standards of Care 1.0: Health Case Management* will apply from the date of transitions. For purposes of the standards, the date of transitions will be considered the initiation of services. The Brief Client Acuity Assessment will be considered the equivalent of the Interim Client Acuity Assessment. Therefore an interim assessment is not required for infants transitioning to ongoing case management services.

Within ninety (90) days of transition date, a Comprehensive Client Acuity Assessment form will be completed. The HCM may complete the comprehensive assessment at any time within the ninety (90) timeframe based upon the established relationship with the infant and his/her parent/guardian.

#### 1.21 Client Closure

Infants should be followed through the determination of their infection status. When the infant is determined to be negative and no further assistance is required, the case may be closed. If the infant required further assistance particularly while participating in clinical trials, the case may remain open. Clinicians/supervisors may authorize the HCM to close the case for infants who are lost to follow-up depending on previous negative PCR test results. If determine to be positive, HCM should transition the infant to ongoing HCM services in accordance with *Standard 1.19*.

When an infant's case is closed, the HCM will complete the Houston Health Case Management Closure Summary form.

### 1.22 Data Entry

Per contract, all required data shall be entered in ARIES within five (5) days of encounter. Data entry shall accurately reflect the information documented in the client record (including the most current client level data, all applicable health indicators as well as dates and duration of encounter).

### 1.23 Tracking of Health Indicators

Currently no existing performance measures can be applied to this type of specialty health case management. However, this standard shall be amended as necessary to comply with performance measures that are developed and can be applied to this service. When performance measures are amended, an implementation process shall be established to allow agency's appropriate time (when available) to comply with the amendment.

However, key health indicators (such as PCR testing, CDC Stage of Illness, etc.) should still be entered into ARIES. When the agency has a question about whether a health indicator should be entered, a written communication should be sent to The Resource Group's Data/IT Manager via email for clarification.

## ADMINISTRATIVE STANDARDS OF CARE

### 2.1 Supervision/Case Review

The supervisor shall document case review in the record, as appropriate. At a minimum, supervisor should be consulted prior to:

- Closing a client;
- Initiation of legal intervention (APS, CPS, etc.); and
- Other actions as outlined by Subgrantee policy.

Required evidence of supervision/case review is as follows:

- The supervisor shall document supervision of health case managers in writing
- The exact manner of documentation will be left to the supervisor
- Documentation must be available for review at quality compliance reviews.

### 2.2 Review of Standards of Care

Review of the Standards of Care for Health Case Management Services shall occur on an annual basis and revisions will be implemented in August of each year. Required changes from HRSA shall be implemented within thirty (30) days of receipt.

### 2.3 Implementation of New/Revised Forms

When a form is added or revised, it should be completed at the client's next scheduled appointment (after the published effective date). It is not required to schedule client appointments for the sole purpose of implement new or revised forms.