STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

Ryan White Part B Client Services Manual

DECEMBER 2023

IOWA HHS

Table of Contents

INTRODUCTION & OVERVIEW 1
- How to Use This Manual 2
- Terminology 3
- Services in Iowa 5

SERVICE DELIVERY 8
- Service Delivery 9
- Achieving Health Equity in Care for PLHIV 9
- Culturally and Linguistically Appropriate Services 10
- Accessibility of Services 11
- Eligibility Criteria 11
- Maintaining a Safe Work Environment 11

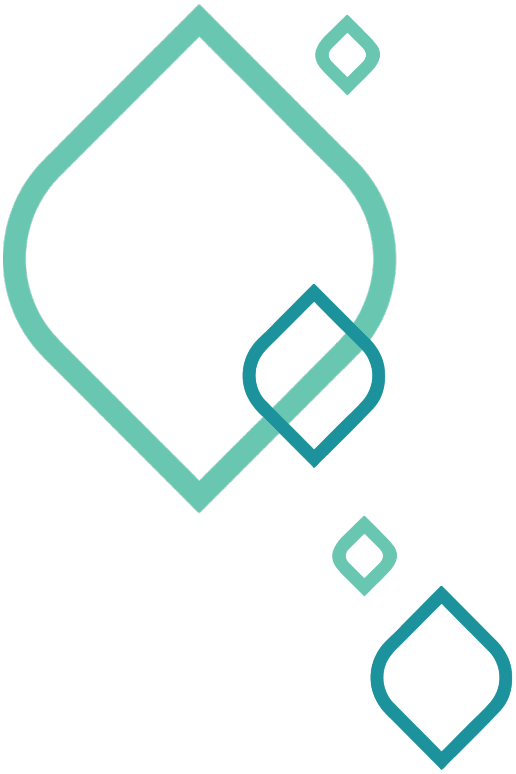
CASE MANAGEMENT 13
- Case Management Background and Framework 14
- Case Management Standards of Care 19
  - Medical Case Management (MCM) 19
  - Non-Medical Case Management (Non-MCM) 20
  - Brief Contact Management (BCM) 20
  - Maintenance Outreach Support Services (MOSS) 21
- Case Management Key Activities 22
  - Initial Referral 22
  - Eligibility Determination 22
  - Assessment and Reassessment 23
  - Goal Development and Monitoring 24
  - Referral and Follow-up 25
  - Consultation with Medical Provider 26
  - Treatment Adherence Planning 26
  - Tier Transition 26
  - Client Transfer 27
  - Client Discharge 27
- Data to Services 28

IOWA HHS

CORE MEDICAL & SUPPORT SERVICES 32
Core Medical and Support Services Standards of Care 33
Core Medical Services 34
AIDS Drug Assistance Program (ADAP) 34
Early Intervention Services 34
Health Insurance Premium & Cost-Sharing Assistance 34
Home and Community-Based Health Services 35
Home Health Care 36
Hospice Services 37
Medical Nutrition Therapy 37
Mental Health Services 38
Oral Health Care 39
Outpatient/Ambulatory Health Services 40
Substance Abuse Outpatient Care 41
Support Services 43
Child Care Services 43
Emergency Financial Assistance 43
Food Bank/Home-Delivered Meals 44
Health Education and Risk Reduction 45
Housing Services 45
Linguistic Services 47
Medical Transportation Services 47
Other Professional Services 48
Outreach Services 49
Psychosocial Support Services 50
Referral for Health Care and Supportive Services 51
Rehabilitation Services 52
Respite Care Services 53
Substance Abuse Services—Residential 54
Other Iowa Programs 56
Delta Dental Insurance Program 56
Tobacco Use Cessation Program 56
Naloxone Program 57
Cell Phone & Internet Assistance Program 58

DOCUMENTATION & FILE MAINTENANCE 60
The Ryan White Electronic Management Information System 61
CAREWare 66
REMI-CAREWare Interface 69
File Maintenance 69
ADMINISTRATION 71
National Monitoring Standards 72
Quality Management Program 72
Fiscal Policies 74
Payer of Last Resort 74
Unallowable Costs 74
Expenditure Monitoring 75
Financial Management 75
Employee Travel 76
Reporting Requirements 77
APPENDICES 78
Appendix A: Iowa Ryan White Part B Provider List 79
Appendix B: Iowa Ryan White Part C Provider List 81
Appendix C: Housing Opportunities for Persons with AIDS (HOPWA) Provider Map & List 83
Appendix D: Core Medical Services Definitions 85
Appendix E: Support Services Definitions 88
Appendix F: Delta Dental Insurance Application 91
Appendix G: Department of Public Health Change Request Form 94
Appendix H: Naloxone Eligibility Assessment 97
Appendix I: Naloxone Application 99
Appendix J: Case Management Enrollment & Client Consent Form 101
Appendix K: Clients Rights, Responsibilities, and Grievance Form 104
Appendix L: Consent to Release Confidential Information 107
Appendix M: Consent to Exchange Confidential Information 109
Appendix N: Diligent Search Checklist 111
Appendix O: Potential False-Positive Test Results Policies and Procedures 113
Appendix P: Core Elements Table 116

INTRODUCTION & OVERVIEW



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HOW TO USE THIS MANUAL

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

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

The manual is divided into six main sections:

Introduction & Overview

This section helps the reader to know how to use the manual, introduces some key terms, and outlines what services are offered in Iowa.

Service Delivery

This section addresses some minimum expectations specific to service delivery that Part B providers are expected to meet.

Case Management

This section includes information on the background and framework of case management in Iowa, standards of care, key activities, and the Data to Services Re-engagement Program.

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

The standards of care and key activities describe in detail Iowa's four-tiered case management program, including core elements and other requirements for each tier. The Data to Services section provides information on retention and re-engagement efforts in Iowa.

Core Medical and Support Services

This section includes guidelines and requirements for core medical and support services that are, or could be, delivered by Iowa Part B providers. This section provides important information to ensure compliance with program requirements for agencies providing these services.

Documentation & File Maintenance

This section includes information about documentation requirements, REMI and CAREWare guidelines, and client file maintenance.

Administration

This section addresses quality management, fiscal policies, and reporting requirements.

Appendices

This section provides information and resources discussed in the manual.

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TERMINOLOGY

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

Benefits and Drug Assistance Program (BDAP) is Iowa's implementation of the federal AIDS Drug Assistance Program (ADAP), which is authorized under Part B of the Ryan White HIV/AIDS Program. The BDAP provides FDA-approved medications and assistance with the costs of health insurance to low-income individuals with HIV.

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

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

Department of Corrections (DOC) is the agency that operates adult prisons in the state.

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

Disease Intervention Specialists (DIS) are public health outreach workers who are responsible for finding and counseling people with sexually transmitted infections and their partners.

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

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

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

Iowa Department of Health and Human Services (Iowa HHS) Iowa HHS is the newly established department in Iowa that includes the former Iowa Department of Public Health and the former Iowa Department of Human Services. The Iowa Ryan White Part B Program is housed in this department in the Bureau of HIV, STI, and Hepatitis within the Division of Public Health.

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

Part B providers are agencies across the state of Iowa, as well as one in Nebraska and one in Illinois, that provide direct Ryan White Part B services to Iowans living with HIV. The Iowa HHS provides funding and guidance to Part B providers (subrecipients) to make these services available.

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

REMI (**R**yan White **E**lectronic **M**anagement **I**nformation System) is the electronic content management system used to manage applications and collect information on services delivered to clients served by the Ryan White Program.

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

Ryan White Part B Program (Iowa RWPB Program) is the program within Iowa HHS that receives Ryan White Part B funding from HRSA to provide core medical and support services, including BDAP, to people living with HIV.

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SERVICES IN IOWA

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

INTRODUCTION

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

HIV case management exists in part to connect an often-fragmented system. It can serve as a catalyst for quality, cost-effective care by linking the patient, the physician, other members of the care coordination team, the payer, and the community. Without the coordination provided by case managers, some clients can become confused about how the system works and frustrated by the time and effort involved. Consequently, many clients can become detached and ultimately disengage from care services. It is important to remember, however, that although the absence of case management can hamper client access to needed services, case managers working in an uncoordinated system can contribute to the fragmented service delivery that case management is meant to alleviate. This is the reason why each case management program is required to develop detailed policy and procedure guidelines. See section F5 for more details.

Ryan White Part B services, which include a multi-level, or tiered, case management system, as well as other core and support services, are provided in a variety of settings in Iowa. These settings include AIDS Service Organizations, health departments, and medical facilities. The Iowa RWPB Program currently contracts with 10 agencies to provide Ryan White Part B services.

PART B SERVICES IN IOWA

Several funding sources are utilized to provide a wide array of core medical and support services geared toward the high-quality care of Iowans living with HIV. Iowa HHS is Iowa's grantee for these Ryan White Part B Program funds. In addition to case management services, Iowa's Ryan White Part B Program may provide funding for the following services:

Core Medical Services

- Benefits and Drug Assistance Program (formerly called ADAP)
- Early Intervention Services
- Health Insurance Premium & Cost-Sharing Assistance
- Home and Community-Based Health Services
- Home Health Care
- Hospice
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Abuse Outpatient Care

Support Services

- Child Care
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Health Education/Risk Reduction
- Housing Services
- Legal Services
- Linguistics Services
- Medical Transportation
- Other Professional Services
- Outreach Services
- Permanency Planning
- Psychosocial Support Services
- Referral for Health Care and Support Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services (residential)

The Iowa RWPB Program contracts with 10 agencies (referred to as Part B providers) to provide case management and other core medical and support services throughout the state. Part B providers deliver essential health and supportive services to financially eligible clients living with HIV. All Ryan White programs are "payers of last resort," meaning that all other resources, including Medicaid and Medicare, need to be exhausted before the Part B Program may pay for a service. In 2022, approximately 2,284 PLHIV received services through the Ryan White Part B Program.

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

PART C SERVICES IN IOWA

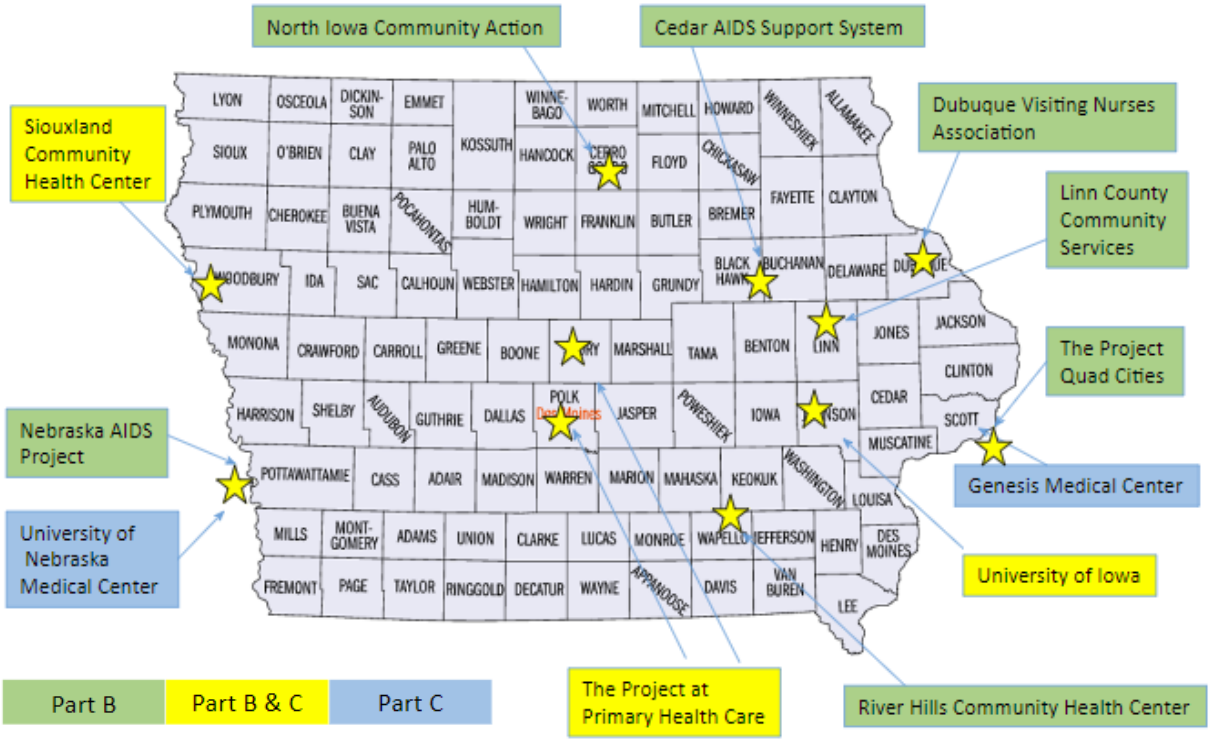
Part C of the Ryan White HIV/AIDS Treatment Extension Act of 2009 provides grants directly to service providers, such as ambulatory medical clinics, to support outpatient HIV early intervention services and ambulatory care (i.e., non-residential, outpatient care). The Part C Early Intervention Services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

In fiscal year 2021, Iowa's Part C clinics received over $1.5 million in Ryan White Part C funding and were able to provide the following services:

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

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

Ryan White Services in Iowa



HOPWA SERVICES IN IOWA

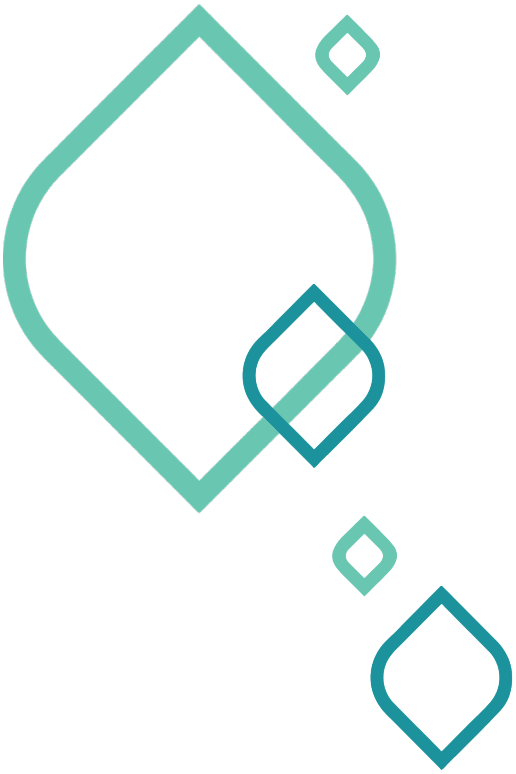
The Housing Opportunities for Persons with AIDS (HOPWA) Program provides housing assistance and related supportive services for low-income PLHIV and their families to establish or maintain a stable living environment in housing that is decent, safe, and sanitary. HOPWA also works to reduce the risk of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

HOPWA provides the following services:

- **Short-Term Rent, Mortgage, & Utilities** (STRMU): needs-based, time-limited housing assistance designed to maintain stable living environments for people who are experiencing a financial crisis and potential loss of their housing arrangement.
- **Tenant-Based Rental Assistance** (TBRA): used to help participants obtain permanent housing that meets housing quality standards at a reasonable rent in the private rental housing market.
- **Permanent Housing Placement** (PHP): used to help eligible persons establish a new permanent housing residence where ongoing occupancy is expected to continue. Frequently used for application fees, related credit checks, reasonable housing and utility security deposits, one time hook-up fees, and payee services.
- **Supportive Services**: a wide range of services that may include education, employment assistance, legal assistance, life skills management, outreach, transportation, health, mental health assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, childcare, nutritional services, intensive care when required, and assistance in gaining access to local, state, and federal government benefits and services.

For a map and full list of Iowa HOPWA providers, refer to Appendix C.

SERVICE DELIVERY



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SERVICE DELIVERY: INTRODUCTION

To ensure the best health outcomes of Iowans living with HIV, as well as to achieve the goals set forth in the *2022-2026 Stop HIV Iowa Integrated Plan*, there are several cross-cutting components that must be considered when providing Ryan White Part B services in Iowa. Agencies are called upon to ensure services are uniquely tailored to achieve health equity in their service area, including culturally and linguistically appropriate services. Services should be widely and easily accessible to serve as many Iowans living with HIV who have needs.

It is also critical that staff providing services have support and are able to work in safe environments.

The following section provides background information and guidance on these service delivery principles.

ACHIEVING HEALTH EQUITY IN CARE FOR PLHIV

It is Iowa HHS's Health Equity mission to protect and improve the health of all people in Iowa where they live, work, learn, and play by uniquely tailoring efforts that advance optimal and equitable health outcomes. A disproportionate percentage of PLHIV come from populations historically underserved by traditional health care systems. These groups often face structural barriers that prevent them from receiving the full benefit of available treatment options, resulting in avoidable disparities in health outcomes.

Health disparities and overall outcomes among PLHIV are largely due to structural and socio-economic factors, known as social determinants of health, rather than individual or group behaviors. To best serve PLHIV, case managers must be mindful of the intersections of environmental, social, and economic systems, and be prepared to meet the needs of client populations who are disadvantaged by those systems. Marginalized groups face barriers to optimal health caused by racism, discrimination, poverty, hazardous environments, homelessness, persistent trauma and/or other conditions that negatively impact their quality of life. PLHIV are likely to have those obstacles compounded by stigma, lack of social support, and chronic health challenges.

Ryan White case management can address disparities by centering health equity to ensure all clients reach their highest possible level of health. Health Equity is a core component of public health (protecting and improving health for all people) and is essential to Ending the HIV Epidemic. Equity means to provide the services needed based upon an individual's unique circumstances and challenges so that each individual can achieve their best health outcomes. Achieving health equity requires care services programs and staff to identify barriers to accessing services and to implement equitable strategies for increasing access for marginalized groups. Men who have sex with men, transgender people, youth, and people of color (men and women) have been identified as groups that consistently experience inequitable health outcomes related to HIV. Some key components of an equitable client services model are:

- Committing to equity at the organizational level
- Identifying disparities using data (quantitative and qualitative)
- Shifting cultural perspectives (cultural responsiveness)
- Incorporating equity into quality and performance improvement strategies
- Educating and engaging community stakeholders

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CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

It is important for clients who are enrolled in the Ryan White Part B Program to receive services that are linguistically and culturally appropriate. Providing culturally and linguistically appropriate services helps improve the quality of services provided and will help reduce health disparities to achieve overall health equity in services.

Ways in which agencies can promote culturally and linguistically appropriate services include:

- Ensuring staff receive ongoing training and education in culturally and linguistically appropriate policies and practices.
- Offering language assistance to clients who have limited English proficiency and/or have other communication needs, at no additional costs to them. Clients should be informed of the availability of language assistance services clearly, and in their preferred language.
- Providing print and media materials and signage in the languages most commonly used by the clients they serve.
- Ensuring that individuals providing language assistance services for translation and interpretation are competent to provide those services and should avoid the use of untrained individuals and/or minors.

KEY DEFINITIONS

Cultural Responsiveness: The ability to identify, appreciate, and respond to cultural differences by adapting one's approach to providing services in ways that correspond with a client's cultural norms and values.

Cultural Humility: The understanding that one must begin with a personal examination of one's own beliefs and cultural identities to better understand the beliefs and cultural identities of others. Cultural humility is a lifelong process of self-reflection (Tervalon & Marray-Garcia, 1998).

Linguistic Competency: The capacity of individuals or institutions to communicate effectively at every point of contact. Effective communication includes the ability to convey information, both verbally and in writing, in a manner that is easily understood by diverse groups, including persons of limited English proficiency, those who have low literacy skills or who are not literate, those having low health literacy, those with disabilities, and those who are deaf or hard of hearing.

Culturally and Linguistically Appropriate Services: Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization at each point of contact with an individual.

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated in whole or in part with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.

Health Equity: The state in which everyone has a fair and just opportunity to attain their highest level of health.

Interpreter: An individual who renders a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

Translation: The conversion of a written text into a corresponding written text in a different language.

The following link provides additional resources to assist in providing culturally and linguistically appropriate services: https://thinkculturalhealth.hhs.gov/clas.

ACCESSIBILITY OF SERVICES

Individuals living with HIV in Iowa should be able to access services regardless of their ability to pay and regardless of their current or past health condition(s). Services should be provided in a setting accessible to low-income PLHIV, and facilities must comply with the Americans with Disabilities Act (ADA) Barriers Free Health Care Initiative. Agencies providing Part B services must have a grievance process in place for PLHIV who are not satisfied with services and wish to file a complaint.

Part B agencies are responsible for disseminating information regarding the HIV-related services they provide and how to access them. Examples of informational materials include newsletters, brochures, posters, social media, and web pages. An ongoing effort to obtain input from PLHIV regarding services is also required. This may include the use of focus groups, Consumer Advisory Boards (CABs), or client satisfaction surveys. Records of these efforts should be maintained and be made available upon request.

ELIGIBILITY CRITERIA

Client eligibility must be determined within 60 days of initial intake and annually thereafter. Eligibility documentation must include proof of HIV diagnosis, proof of residency, and proof of income. Documentation must be stored in the client's electronic file.

Eligibility criteria in Iowa includes:

- HIV diagnosis
- Iowa residency
- Income at or below 500% Federal Poverty Level (FPL)

The case manager must obtain an Exception to Policy from the Iowa RWPB Program for clients who are seeking case management or other core medical and support services but whose income is over 500% FPL. An approved Exception to Policy is valid for a maximum of one year. Clients who do not reside in Iowa or who are not living with HIV are not eligible for an Exception to Policy.

MAINTAINING A SAFE WORK ENVIRONMENT

Ryan White Part B staff have the right to work in an environment in which they feel safe and respected. Violent, threatening, and/or verbally abusive behavior from clients shall be addressed swiftly and firmly. When enrolling in case management services clients shall be required to sign the Client's Rights, Responsibilities, and Grievance Form indicating agreement in the responsibility to display behavior that is not violent, threatening, or verbally abusive. See Appendix K to review the Client's Rights and Responsibilities form.

PROCEDURE

If a client becomes verbally abusive, threatening, or violent towards staff, staff shall immediately take steps to de-escalate the situation. Common de-escalation techniques include remaining calm, being empathetic, speaking in a low tone, and using active listening skills. Staff may refer the client to a supervisor, or ask a supervisor to help resolve the situation.

If staff feel the threat of harm is imminent, staff shall attempt to move themselves and others out of harm's way, request assistance from other staff members, and call 911 if necessary.

All incidents involving verbal abuse, threats, and violence shall be reported to a direct supervisor and documented in case notes.

PROACTIVE MEASURES

If a client has a history of threats, violence, or verbal abuse, or a staff member has reason to believe a meeting may become volatile, staff shall take proactive measures when scheduling in-person visits with the client. These measures may include all or any combination of the following:

- Discuss behavior expectations with the client prior to scheduling the meeting. This may include reviewing the Client's Rights and Responsibilities form.
- Have a supervisor or other staff member present for the meeting.
- Ensure a direct and safe exit from the meeting by sitting between the individual and the door.
- Notify other staff ahead of time that a client may become upset during the meeting so they are prepared to assist if needed.
- Schedule the visit virtually rather than in-person if possible.

If the client has been diagnosed with or is showing signs of a serious mental illness that may be impacting his/her/their behavior, the Iowa RWPB Program recommends the case manager consult with a Behavior Health Consultant or licensed mental health provider for guidance on how to interact with the client to maximize positive outcomes.

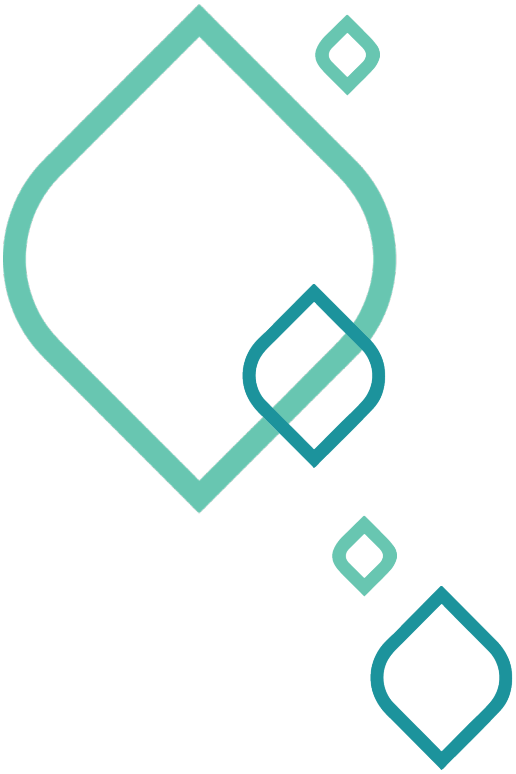
SERVICE PROVISION FOR DISRUPTIVE CLIENTS

If a staff member no longer feels safe providing services to a client due to hostile behavior, the situation shall be reviewed with the Ryan White Part B Program Manager at Iowa HHS. The Ryan White Part B Program Manager shall review options to help ensure staff safety, while also making attempts to ensure the client is able to continue to access vital core medical and support services. Options for continued case management may include:

- Ceasing all in-person visits and providing case management to the client through options that don't require direct contact, including phone, mail, email, and text messaging
- Assigning the client a different case manager
- Having the agency Ryan White Part B Program Manager or a qualified designee provide case management to the client.

If the client continues to display hostile behavior or the agency Ryan White Part B Program Manager determines it is not safe or appropriate for that agency to continue providing case management to the client, the Program Manager shall contact the Ryan White Part B Client Services Coordinators for assistance. The Client Services Coordinators will review each case individually and make a determination of next steps according to the circumstances of that individual situation.

CASE MANAGEMENT



CASE MANAGEMENT BACKGROUND AND FRAMEWORK

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

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

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

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

WHAT IS CASE MANAGEMENT?

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

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

In general, case management is used to:

- Assess client service needs
- Determine client eligibility for benefits and services and aid clients in applying for assistance
- Coordinate support services and care from different providers to meet clients' needs

- Implement disease management, which generally includes client education, counseling, client appointment and medication reminders, routine reporting to providers and clients, and other activities to promote quality of care while achieving cost efficiencies
- Advocate for clients, and empower clients to advocate for themselves

WHY IS CASE MANAGEMENT IMPORTANT FOR PEOPLE LIVING WITH HIV?

According to the CDC, in 2019 approximately 1.2 million Americans were living with HIV, and approximately 1 in 8 people are unaware that they are living with the virus. For those living with HIV, the medical outlook is vastly different today than it was in the early days of the epidemic, when treatment was largely palliative, and life expectancies following diagnosis were relatively short. Today's treatments have transformed HIV from what was once an acute, fatal condition to a chronic, manageable disease. Individuals with the virus have the potential to live long, productive, fulfilling lives. However, many face barriers that prevent them from receiving the full benefit of available treatment options and achieving their potential to live full lives.

A significant proportion of PLHIV come from populations historically underserved by traditional health care systems and presented with significant societal challenges that are structural and systemic in nature. As a result, many struggle with substance abuse problems, homelessness, and mental illness. Men who have sex with men, transgender persons, youth, and people of color (men and women) are disproportionately affected.

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

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

Studies have found a high level of need for care and support services among PLHIV. Research suggests that case management is an effective approach for addressing the complex needs of chronically ill clients. Case management can help improve a client's quality of life, satisfaction with care, and use of community-based services. Case management also helps reduce the cost of care by decreasing the number of hospitalizations a client undergoes to address HIV-related medical conditions.

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

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

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

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

ROLE AND ACTIVITIES OF CASE MANAGER

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

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

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

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

- **Assessment** is a cooperative and interactive information-gathering process between the client and the case manager through which an individual's current and potential needs, weaknesses, challenges, goals, resources, and strengths are identified and evaluated for the development of a treatment plan. The accuracy and comprehensiveness of the assessment depends on the type of tool used, the case manager's skill level and the reliability of information provided by the client.
- **Planning** is a cooperative and interactive process between the case manager and the client that involves the development of an individualized treatment and service plan based on client needs and available resources. Planning also includes the establishment of short-term and long-term goals for action.
- **Coordination and Linkage** connects clients to appropriate services and treatment in accordance with their service plans, reduces barriers to access, and reduces duplication of effort between case management programs. Coordination includes advocating for clients who have been denied services for which they are eligible.
- **Monitoring and reassessment** is an ongoing process in which case managers continually evaluate and follow up with clients to assess their progress and to determine the need for changes to service and treatment plans.
- **Discharge** involves transitioning clients out of case management services because they no longer need them, have moved, or have passed away. For clients who move to other service areas, case managers should work to establish the appropriate referrals and facilitate warm handoffs when possible.

CLIENT-CENTERED APPROACH TO CASE MANAGEMENT

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

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

It is the case manager's responsibility to:

- Offer accurate information to the client

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

IOWA'S CASE MANAGEMENT MODEL

Case Management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for PLHIV. The goal of case management is to promote and support independence and self-sufficiency. As such, the case management process requires the consent and active participation of the client in decision-making, and it supports a client's right to privacy, confidentiality, self-determination, dignity, and respect. Case management should include compassionate, non-judgmental care from a culturally responsive provider.

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

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

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

Non-Medical Case Management (Non-MCM) is a case management model intended to serve PLHIV who have complex psychosocial needs. This level is designed to serve individuals who may require a maintenance level of periodic support to stabilize their psychosocial needs. Non-MCM clients manage their care well enough to avoid chronic disruption to their medical care, but they still require psychosocial support to maintain a stable lifestyle.

Brief Contact Management (BCM) is a case management model intended to support independence in decision-making and in accessing services for health-related and/or psychosocial needs. This level is designed to assist individuals whose needs are minimal and infrequent. The BCM level is suitable for persons who exhibit a high level of understanding and acceptance of HIV. BCM clients have the life skills and personal resources to self-manage their care with only occasional assistance from a case manager.

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

IOWA HHS

CASE MANAGEMENT STANDARDS OF CARE

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

This section provides the standards of care for the Ryan White Case Management services that are currently provided in Iowa. The standards begin with a brief description of each tier which includes service units and key activities. The key activities are then outlined in the Case Management Key Activities section immediately following the tier descriptions.

MEDICAL CASE MANAGEMENT (MCM)

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

MCM services are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatment is an important component of MCM. This level of service ensures timely and coordinated access to medically appropriate levels of health and support services. It also focuses on ensuring continuity of care through ongoing assessment of the client's needs, including the client's ability to access long-term support for healthcare costs through Medicaid, Medicare, BDAP-sponsored insurance, or private insurance plans.

MCM services must be culturally and linguistically appropriate to the populations served. MCM may be delivered face to face, via telephone, or using other forms of communication appropriate for the client. A primary goal of MCM is to help clients address barriers directly affecting their abilities to adhere to medical advice. MCM's hallmark characteristic is having the case manager work directly with the client's HIV medical provider to address these issues.

Service units of MCM services are documented in REMI or CAREWare in 15-minute increments as "In MCM/RWB" for services provided in the office/clinic or "Out MCM/RWB" for services provided out of the office/clinic.

Key Activities

- Initial Referral
- Eligibility Determination
- Assessment and Reassessment
- Goal Development & Monitoring
- Referrals and Follow Up
- Consulting with medical providers
- Treatment adherence planning
- Tier Transition

NON-MEDICAL CASE MANAGEMENT (NON-MCM)

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

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

Non-MCM includes the provision of referrals and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-MCM does **not** require consultation with the client's medical provider or treatment adherence planning as MCM does, but these activities may be appropriate based on the client's individual situation.

Service units of Non-MCM services are documented in REMI or CAREWare in 15-minute increments as "In Non-MCM/RWB" for services provided in the office/clinic or "Out Non-MCM/RWB" for services provided out of the office/clinic.

Key Activities

- Initial Referral
- Eligibility Determination
- Assessment and Reassessment
- Goal Development & Monitoring
- Referrals and Follow Up
- Tier Transition

BRIEF CONTACT MANAGEMENT (BCM)

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

The BCM model gives the client the opportunity to graduate from more intensive tiers of case management into a self-management tier. Upon request, the client may receive advice and/or assistance in obtaining medical, social, community, legal, financial, and other needed services. BCM does not require coordination and follow up on medical treatments or the development and monitoring of goals though these activities may be appropriate based on the client's individual situation.

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

Service units of BCM services are documented in REMI or CAREWare in 15-minute increments as "In BCM/RWB" for services provided in the office/clinic or "Out BCM/RWB" for services provided out of the office/clinic.

Key Activities

- Eligibility Determination
- Assessment and Reassessment
- Referrals and Follow Up
- Tier Transition

MAINTENANCE OUTREACH SUPPORT SERVICES (MOSS)

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

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

Clients should not be admitted directly to MOSS services. All clients should have an opportunity to have a period of more intensive service (MCM, Non-MCM, or BCM) to ensure needs have been met and a trusting relationship has been established with the case manager prior to being transferred to MOSS. Clients must receive three months of MCM or Non-MCM case management prior to transitioning to MOSS.

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

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

Service units of MOSS are documented in 15-minute increments as "MOSS/RWB" in REMI or CAREWare.

Key Activities

- Eligibility Determination
- Assessment and Reassessment
- Referrals and Follow Up
- Tier Transition

IOWA HHS

CASE MANAGEMENT KEY ACTIVITIES

INITIAL REFERRAL

Referrals are important touchpoints: By definition, clients receiving referrals are in a time of change and, perhaps, flux. It is a critical part of case management to welcome and engage clients during this phase to encourage long-term engagement in their care.

Initial referrals to Iowa Ryan White Part B Program sites are received from a variety of sources, including public health agencies, Disease Intervention Specialists, other Ryan White Part B agencies, Ryan White Part C agencies, medical providers, hospitals/emergency rooms, testing sites, and family/friends. Any site receiving a referral must attempt to contact the newly referred client within **one to two business days**. Initial contact attempts with a referred client should be a high priority and conducted by any appropriate staff, which may include the case manager, program support staff, supervisor, nurses, or other appropriate Part B staff. If contact cannot be established with the client within **five business days**, the referral source should be contacted for assistance in connecting with the client.

Best Practice: Initial contact attempts occur within **one business day.**

ELIGIBILITY DETERMINATION

Eligibility determination is the process for collecting the required documents to determine eligibility for Ryan White Part B services based on Iowa eligibility criteria. All services require the following documents: proof of HIV diagnosis, proof of residency, and proof of income. Eligibility documentation is reviewed annually and stored in the client's electronic file. For clients enrolled in MOSS case management services, self-attestation is an acceptable proof of eligibility.

Eligibility criteria includes:

- HIV diagnosis
- Iowa residency
- Income at or below 500% FPL

In some unique situations, an exception to this policy may be granted if an Iowa resident diagnosed with HIV is seeking assistance with health-related expenses but is over 500% of the Federal Poverty Level (FPL). The case manager must obtain an approved *Exception to Policy* form from the Iowa RWPB program prior to providing case management and/or other core medical and support services. An approved Exception to Policy is valid for a maximum of one year. Clients who do not reside in Iowa or who are not diagnosed with HIV are not eligible for an Exception to Policy.

Proof of diagnosis is required for newly enrolled clients. Acceptable proof of diagnosis includes:

- Confirmation of HIV diagnosis from their treating physician
- Copy of a confirmed positive test result (Western blot/IFA, Multispot HIV-1/HIV-2 rapid test)
- Copy of a positive nucleic acid amplification test (NAAT, PCR, bDNA, LCR)
- Copy of a viral load test showing a detectable quantity of virus.
- Ryan White Program Eligibility form completed by the Iowa HHS HIV Surveillance Office

Please see Appendix O: Potential False-Positive Test Results Policies and Procedures if you are working with an individual whose HIV status is in question due to a possible false-positive test result.

Acceptable proof of income includes:

- Pay stubs for a full thirty days of consecutive income
- Signed employer statements with dates, position, salary, and phone number
- Long- or Short-Term Disability Award Letter indicating the pay period length
- Current year's Social Security award letter (SSA, SSI, SSDI)
- Documentation of alimony and/or child support
- Income tax returns (acceptable only for self-employed individuals)
- Contracts, ledgers (acceptable only for self-employed individuals)
- Unemployment benefits statement
- Veterans Affairs benefits statement
- Retirement benefits statement

Documentation of residency verification must be in the client's name, include the client's current address, and be dated within the last three months. Acceptable proof of residency includes:

- Copy of lease with current dates and signatures (electronic signatures are acceptable)
- Rent receipt
- Paystubs
- Utility, home telephone, cable, or cell phone bill
- Credit card bill
- Property tax statement
- SSDI, or other government program/assistance award letter
- Letter addressed in the client's name received via US mail with postmark
- Medical bills or statements received via US mail
- Mortgage statement
- Letter from case manager attesting they have physically visited the client's residence
- Letter from case manager attesting that the client is experiencing homelessness
- Letter from shelter attesting that the client is residing at the shelter
- Self-attestation that client is participating in a "Safe at Home" or other Address Confidentiality Program

ASSESSMENT AND REASSESSMENT

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

- Timely access to appropriate levels of core medical and support services
- An ongoing assessment of the client's needs
- A concerted effort with other Ryan White agencies and community resources

Annual Assessment (MCM, non-MCM, and BCM)

The case manager works collaboratively with the client to complete a comprehensive Annual Assessment to assess the need for medical, dental, psychosocial, educational, financial, nutritional, mental health, substance use, risk reduction, and other services. The required sections (red sections) of the assessment must be completed within 60 days. The remaining sections of the assessment should be completed at a speed appropriate for the client. The case manager should use the Acuity Scale as a measurement tool to determine the client's level of need. The acuity scale indicates the recommended tier of case management.

Best Practice: Annual Assessment is conducted face-to-face.

Documentation:

- Annual Assessment is completed according to standard and present in the client's electronic file.
- Acuity Scale is completed and present in the client's electronic file.
- A case note summarizing assessment is completed and present in the client's electronic file.
- The Case Management Enrollment and Client Consent Form is completed once upon initial enrollment and present in the client's electronic file.
- The Client Rights, Responsibilities, and Grievance Procedure form is completed once upon initial enrollment and present in the client's electronic file.

Annual Assessment (MOSS)

The case manager completes an Annual MOSS Assessment once a year for clients enrolled in MOSS. The MOSS Assessment includes a brief assessment of the following areas: residency, contact information, income, housing, transportation, health insurance, and a narrative section that may include HIV medication adherence, HIV medical care, general medical, sexual health, hepatitis C status, vision/oral health, nutrition and wellness, mental health, substance use, legal, and support system. MOSS Assessments can be conducted face to face, virtually, or via phone.

Documentation:

- Annual MOSS Assessment is completed and present in the client's electronic file.
- Acuity Scale is completed and present in the client's electronic file.
- A case note summarizing assessment is completed and present in the client's electronic file.

GOAL DEVELOPMENT AND MONITORING

Goals are the crux of case management and are used to help the client identify and address barriers impeding their ability to obtain services independently. Together, the client and case manager identify barriers to care and strategies for overcoming those barriers. Goals aid the case manager in assessing appropriate referrals to help the client achieve a desired outcome and enhance the client's health status and quality of life.

Clients receiving MCM or Non-MCM services are required to have a minimum of one active goal at all times. A minimum of one active goal must be related to medical care for clients receiving MCM services.

Best Practice: Clients enrolled in BCM have active goals when significant needs or barriers are identified.

The client's individualized goals should be strengths-based and systematically identify the client's needs based on the Annual Assessment. The case manager and client work together to determine a reasonable timeline for achievement of goals and identify who will be responsible for each task. The majority of tasks should be assigned to the client.

The monitoring of goals is critical to ensuring best health outcomes for the client. Monitoring is an ongoing process that includes, but is not limited to, the following activities:

- Contact with the client in person, by phone, text, or email
- Conducting ongoing follow up with the client to confirm completion of referrals, service acquisition, maintenance of services, and adherence to medical care
- Evaluating the client's progress and appropriateness of services
- Assisting the client in resolving any barriers to completing goals.

The frequency of monitoring and updating goals is dependent on the level and intensity of the client's need, but must occur at least every six months. Goals are updated when:

- Unanticipated changes take place in the client's life
- A change with a goal is identified
- A goal is achieved.

Goals, objectives, action steps, and progress notes are documented in case notes and/or in the *Goals* feature of the client's electronic chart, and may include the following:

- Information about encounters with the client, including date of encounter, type of encounter, duration of encounter, and services provided
- Contacts with the client's support system, providers, and other relevant individuals
- Progress made toward goal completion
- Barriers identified and actions taken to resolve barriers
- Current status and results of referrals.

REFERRAL AND FOLLOW-UP

Often, to address the barriers that clients face most effectively, a referral to another agency or program must be made. Referrals should be appropriate to the client's situation and should assist them in achieving optimal health and well-being. After a referral is made, the case manager follows up to ensure that the client is accessing needed services and to help resolve any barriers the client may have in following through with the referral. The case manager contacts the client to ensure completion of the referral.

Referrals should include:

- Name and phone number of referral agency
- Name of a contact person at the referral agency
- Specific address of referral agency
- Specific instructions on how to make the appointment
- Eligibility requirements for referral agency
- What to bring to the appointment.

All elements of a referral are documented in case notes and/or in the *Referral* feature of the client's electronic chart and include:

- Follow up activities
- Barriers to referral and action taken to resolve barriers
- Outcome.

CONSULTATION WITH MEDICAL PROVIDER

Direct consultation with the client's HIV medical provider team is the hallmark of MCM. Without this component, MCM is not occurring. This activity is critical to ensuring the highest likelihood for the best health outcomes for the newly diagnosed and those with complex medical needs. Consultation takes place a minimum of twice a year, or as clinically indicated, and must include, at a minimum, the HIV provider or nurse, the case manager, and any other medical or service provider deemed necessary. Case reviews may take place face to face, by phone, or electronically. Case managers should make referrals to an HIV provider for clients who are not engaged in HIV care (see Referral and Follow Up section above).

Case managers will revise the client's goal(s) related to medical care as changes in the client circumstances warrant, or at a minimum of once every six months. Updates will be documented in the *Active Goals* feature in REMI.

Contact with the client's HIV medical provider team is documented in case notes and the following must be included in the client's electronic file:

- HIV care provider name and clinic
- All current medications
- Date of last clinic visit
- Results of last CD4+ cell count and viral load (uploaded automatically by Iowa HHS).

TREATMENT ADHERENCE PLANNING

Treatment adherence planning is the ongoing process of assessing a client's need for adherence education and support in an effort to provide clients with the necessary skills, information, and assistance to follow their HIV provider's treatment recommendations. Case managers are responsible for the continued assessment of a client's adherence needs and goals. Case managers should directly provide or link clients to needed treatment adherence services. Adherence planning activities are documented in case notes and/or in the Active Goals & Referrals feature in REMI.

TIER TRANSITION

Tier transition is a systematic process for transitioning clients from one tier to another, ensuring the most appropriate level of case management is provided. As the client demonstrates an increased ability to independently manage their care, the case manager will transfer the client to a less intensive level of case management to support the client's move toward empowerment, self-determination, and self-sufficiency. Alternatively, when a client has an increase in barriers to managing their care, the case manager will transfer the client to a higher level of case management. To do this, the case manager should complete an updated Acuity Scale in REMI and a summary case note documenting the reason for the tier change.

All clients new to Ryan White Part B case management in Iowa or transferring to a different Ryan White Part B agency in Iowa will be tiered MCM or Non-MCM for a minimum of three months before transitioning to a lower tier. Tier transition can take place any time after the first three months. To transition a client to BCM or MOSS, all required sections of the Annual Assessment must be completed. Clients transitioned to MOSS may no longer receive any financial assistance, including BDAP and HOPWA. The case manager should assess for appropriate tier placement at a minimum of once a year.

A client's level of case management should align with the tier on the client's most recent Acuity Scale.

When completing an Acuity Scale, the case manager will select the recommended tier or will document on the Acuity Scale the reason for not choosing the recommended tier.

CLIENT TRANSFER

Client Transfer is a systematic process for transferring a client from one Ryan White Part B agency in Iowa to another Ryan White Part B agency in Iowa. Transfers most commonly occur when a client relocates within Iowa, although clients may choose to transfer for other reasons and at any time. This process includes completing a Transfer Form in REMI.

The transfer process begins with the client's current case manager obtaining oral or written consent from the client to contact the new agency. The case manager then reaches out to the new agency to discuss the client's transfer situation. The current case manager then begins the Transfer Application in REMI. When the client is ready to enroll at the new Ryan White Part B agency, the new case manager completes the Transfer Application in REMI.

Once the transfer application is completed in REMI, the client's file moves from their old case management agency to their new one.

CLIENT DISCHARGE

Client Discharge is a systematic process for discharging a client from case management services in Iowa due to long-term incarceration, relocation outside of Iowa, transfer to another Ryan White Part B agency in Iowa, voluntary withdrawal, ineligibility, death, lost to case management, and/or severe, inappropriate, threatening, or otherwise destructive behavior on the part of the client that makes continuation of services dangerous to the staff or unlikely to be helpful to the client.

Documentation must include:

- Case note thoroughly documenting discharge
- Discharge form in REMI
- Completion of all pending forms in REMI
- Closure of all open goals and referrals in REMI
- Delta Dental's Department of Public Health Change Request Form (if applicable)
- Client's status updated in REMI and CAREWare according to the table on the next page.

Client Status in Instances of Discharge

Reason for Discharge	CAREWare Enrollment Status	REMI Enrollment Status
Moved out of state	Relocated	Discharged
Incarcerated	Referred or Discharged	Discharged
Deceased	Referred or Discharged	Discharged
Self-Sufficient	Referred or Discharged	Discharged
Ineligibility	Referred or Discharged	Discharged
Death	Referred or Discharged	Discharged
Lost to case management	Referred or Discharged	Discharged
Severe inappropriate, threatening, or otherwise destructive behavior	Removed	Discharged

DATA TO SERVICES

Iowa's Data to Services (DTS) initiative is a collaboration among all programs and initiatives within the Bureau of HIV, STI, and Hepatitis, as well as with providers of HIV medical and support services throughout the state. The initiative aims to identify, prioritize, retain, and re-engage PLHIV who are not receiving medical care or other support services. Retaining and re-engaging individuals in care is of utmost importance from both an individual and public health prevention standpoint. When a PLHIV is engaged in HIV care and adherent to antiretroviral therapy (ART), they are more likely to achieve viral suppression and have better health outcomes. At the same time, the likelihood of transmission to a sex partner is highly unlikely.

Data to Services Objectives:

- Reduce the number of people living with HIV who are not receiving primary health care
- Increase the number of people living with HIV who are virally suppressed
- Assess demographics and identify trends in Iowa's not-in-care population
- Identify the most commonly cited barriers by Iowans who are out of care
- Identify outreach activities that result in successful retention and re-engagement
- Assess ongoing retention in care of clients who have re-engaged
- Maintain timely surveillance records of residency and vital status

DTS RE-ENGAGEMENT ACTIVITIES

Case manager re-engagement activities include:

- Identifying clients who are lost to care or are at high risk of falling out of care
- Requesting Data to Services (DTS) investigations when appropriate
- Participating in case consultations facilitated by the Data to Services Coordinator (DTSC)
- Participating in creating an outreach plan
- Conducting outreach activities based on the outreach plan
- Submitting Part B discharges, as needed

DILIGENT SEARCH

A proactive response should be implemented when working with clients who are not participating in medical care or case management, or who are at risk of falling out of care. Case managers should use all allowable methods of contact in their diligent search efforts. This includes, but is not limited to, telephone, text, email, mail, and in-person outreach. Efforts should also include reaching out to emergency contacts, medical providers, pharmacies, and other appropriate individuals when a current Release of Information is on file. See Appendix N or use the following link to access the Diligent Search Checklist for guidance on determining when all methods of contact have been exhausted. There is no particular order for the steps from the checklist tool and some steps may need to be completed multiple times. The checklist is an optional tool. Its goal is to provide guidance but still leave flexibility for case managers to be client-centered. An appropriate timeline for initial outreach and next steps will vary based on each client's individual situation.

DTS INVESTIGATIONS

For clients who appear to be lost to medical care or case management, the case manager will request a DTS investigation once all methods of contact have been exhausted. The case manager can do this by contacting the DTSC through secure email. Case managers may also request a DTS investigation when:

- Updated client contact information is needed
- The client may have moved out of state
- The client may be in care elsewhere.

DTS investigation requests should include:

- Contact information on file and results of contact attempts (i.e. disconnected phone number, returned mail)
- Overview of contact efforts—pharmacy, emergency contacts, medical providers, home visits, etc.
- Fill history— date of last ARV fill
- Most recent lab information.

DTS investigations are conducted by the DTSC using state and national data systems, social media, and other databases to obtain updated client information, such as vital status, contact information, place of residence, incarceration status, and most recent lab information. The DTSC will search for locating information to determine if the client still resides in Iowa, has moved to another region within Iowa, or has relocated out of state. The DTSC will also look for recent lab results or evidence that the client is

engaged in medical care or case management services elsewhere. Updates will be provided back to the case manager along with recommended next steps.

Client Relocated Out of Iowa

If it is determined a client has relocated out of state, the DTSC will contact the client's new state to verify their care status and contact information to update their record in eHARS. The DTSC will notify the case manager and advise them to submit a Client Services Discharge form in REMI using the reason 'Moved out of state.' The case manager does not need to wait for the DTSC to contact the client's new state to submit the discharge form.

Client Relocated within Iowa

If it is determined a client has relocated within Iowa, the DTSC will notify the case manager and advise them to submit a Client Services Discharge form or a Transfer form in REMI, depending on the specific situation.

CASE CONSULTATION & OUTREACH PLANS

If the client appears to be truly out of medical care and/or case management, the DTSC will request to schedule a case consultation with the case manager and any other appropriate service providers —nurse care managers, disease intervention specialists, behavioral health consultants, etc. A case consultation is the process for gathering all information about the client's situation in an effort to determine next steps in the re-engagement process. There is no "one size fits all" approach to re-engagement. Re-engagement is an individualized approach based on the client's specific needs and barriers, and planning for the next steps in the re-engagement process will take all of this into account. Once next steps are determined for outreach, action on these steps will be taken by the appropriate staff and updates on progress should be provided to all those involved in the case consultation.

DTS Process Complete and Client Re-engaged in Medical Care and Case Management

If the client is re-engaged into medical care and support services, the case manager should continue to provide services per standards and assess the client's engagement and retention in medical care.

DTS Process Complete and Client Re-engaged in Medical Care Only

If the client is re-engaged into medical care but declines case management services, the DTSC will approve discharging the client. The case manager will complete a Client Services Discharge form in REMI and use the reason "Lost to Case Management."

DTS Process Complete and Client Deemed to be In Medical Care

If it is determined that the client is engaged in medical care and virally suppressed, but there is still no follow up to contact attempts, the case manager may assume that the client is not interested in case management services. If there is up to date contact information for the client, the DTSC may request that the case manager mail a letter to the client letting them know that they will be discharged from client services effective immediately. The case manager should provide contact information and re-enrollment process details should the client want to resume services in the future. With the DTSC's prior approval, the case manager will complete a Client Services Discharge form in REMI and use the reason "Lost to Case Management."

DTS Process Complete and Client Deemed to be Out of Medical Care/Case Management

If the process is completed without success the client will be deemed out of medical care and case management. If there is up-to-date contact information for the client, the DTSC may request that the case manager mail a letter to the client letting them know that they will be discharged from client services effective immediately. The case manager should provide contact information and re-enrollment process details should the client want to resume services in the future. With DTSC's prior approval, the case manager will complete a Client Services Discharge form in REMI and use the reason "Lost to Medical Care."

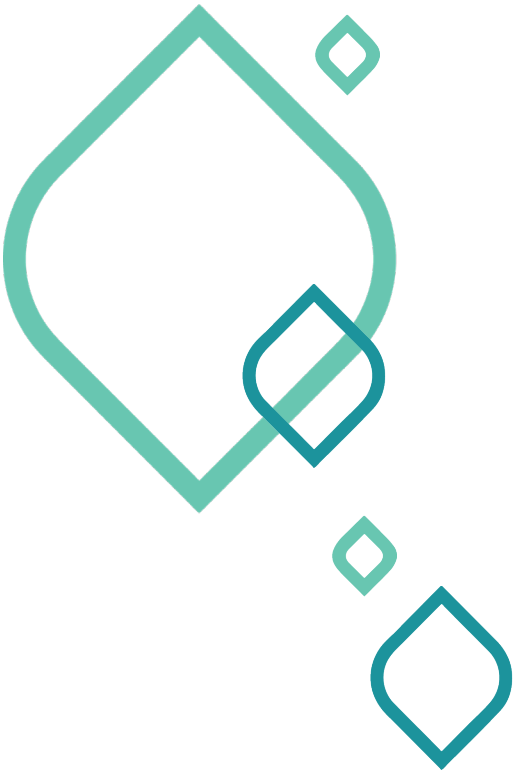
Documentation

As clients move through the Data to Services process, they should remain "open and active" in the REMI and CAREWare systems. Clients should remain at their predetermined case management tier and any outreach attempts should receive the service entry that corresponds to their case management tier. Activities and progress updates are documented in case notes and should be communicated with the DTSC.

When discharging a client after the re-engagement process has been completed, the following information should be included in discharge notes:

- Most recent lab values and date —along with location of where the client is receiving care
- Date of last successful contact with client
- Date(s) of DTS investigation request and case consultation
- Reason for discharge (e.g., client is lost to case management services and is no longer engaging in medical care)
- Summary of contact attempts and results, if applicable.

CORE MEDICAL & SUPPORT SERVICES



IOWA HHS

CORE MEDICAL & SUPPORT SERVICES STANDARDS OF CARE

Standards provide a direction to the delivery of HIV services. They provide a framework for evaluating services and define the professional case manager's accountability to the public and to the client. Standards of care are the minimum requirements, not necessarily best practice, that programs are expected to meet when providing core medical and support services funded by the Iowa RWPB Program.

This section provides the standards of care for the Ryan White Core Medical and Support Services that are provided in Iowa. Refer to Appendix D for a list of Core Medical definitions and Appendix E for Support Services definitions.

PAYER OF LAST RESORT

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

UNALLOWABLE COSTS

Ryan White funds may not be used to make cash payments to clients of Ryan White-funded services. This prohibition includes cash incentives and cash payment for Ryan White core medical and support services. Where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Agencies are advised to administer voucher and store gift card programs in a manner that assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.

Other unallowable costs include:

- Emergency Room visits
- Inpatient services
- Outpatient surgery under general anesthesia
- Clothing
- Pet food and supplies
- Furniture and appliances
- Maintenance of personal vehicles
- Funeral and burial expenses
- Property taxes, local and state taxes
- Clinical trials
- Massage
- Gym memberships / recreational activities
- Mortgages / Deposits
- Pre-exposure prophylaxis (PrEP)
- Non-occupational post-exposure prophylaxis (nPEP)
- Materials promoting IV drug use or sexual activity
- International travel

Other funding sources may be available for these services. Please contact a Client Services Coordinator for more information.

CORE MEDICAL SERVICES

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

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

The BDAP Manual is available to provide guidance regarding benefits and drug assistance. For additional guidance, contact the BDAP office at 515-204-3746 or via email at adap.administrator@idph.iowa.gov.

EARLY INTERVENTION SERVICES

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

The following four components are required:

- Targeted HIV testing
- Referral services
- Access and linkage to HIV care and treatment services
- Outreach Services and Health Education/Risk Reduction services related to HIV diagnosis

The Integrated Testing Services Program Manual is available to provide guidance on Early Intervention Services.

HEALTH INSURANCE PREMIUM & COST-SHARING ASSISTANCE

Health Insurance Premium & Cost-Sharing Assistance (HIPCSA) is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, co-insurance, co-payments, and deductibles.

Examples of allowable HIPCSA services include health insurance premiums, dental insurance premiums, medication co-pays not covered by the BDAP formulary, mental health co-payments, etc.

Service Limitations:

- Health insurance premium payments are limited to insurance plans that provide comprehensive primary care, offer a full range of HIV medications, and have been proven to be cost-effective.
- Dental insurance premium payments are limited to insurance plans that provide comprehensive oral health services, and have been proven to be cost-effective.
- Services limited to outpatient services.
- Outpatient services performed under general anesthesia are unallowable. Other funding sources may be available for these services. Please contact a Client Services Coordinator for more information.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Health Insurance Premium & Cost-Sharing Assistance application
- Supporting documentation.

A HIPCSA application must be completed in REMI for all clients receiving a HIPCSA service. Supporting documentation is required and should be attached to the HIPCSA application. Multiple HIPCSA services can be requested on one application.

Service units of Health Insurance Premium & Cost-Sharing Assistance are documented per service provided (i.e., one payment equals one service unit) as "Health Insurance Premium & Cost-Sharing Assistance" in REMI or CAREWare with a corresponding dollar amount. If more than one HIPCSA service is provided on the same day, the dollar amount will be the total of expenses paid.

HOME- AND COMMUNITY-BASED HEALTH SERVICES

Home and Community-Based Health Services are skilled health services provided to the individual in an integrated setting appropriate to the client's needs and based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. The written plan of care must specify the types of services needed along with the quantity and duration of services.

Examples of allowable Home and Community-Based Health Services include durable medical equipment, home health aide services and personal care services in the home, day treatment or other partial hospitalization services, and appropriate mental health, developmental, and rehabilitation services.

Service Limitations:

- Services provided in nursing homes, other long-term care facilities, and inpatient hospital settings are not allowable.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Written plan of care (see below for details)
- Type of service provided
- Date service was provided
- Location service was provided
- Signature of professional providing the service at each visit (upon request)

Plan of Care is required and must include:

- Type of services needed
- Quantity and duration of services

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving a Home and Community-Based Health Service. Supporting documentation is required and should be attached to the EFA application. Multiple Home and Community-Based Health Services can be requested on one application. The use of the EFA application for Home and Community-Based Health Services is temporary while an Other Financial Assistance Application is being developed in REMI.

Service units of Home and Community-Based Health Services are documented per service provided (i.e., one payment equals one service unit) as "Home and Community-Based Health Services" in REMI or CAREWare with a corresponding dollar amount.

HOME HEALTH CARE

Home Health Care is the provision of services in the home by licensed health care providers, such as nurses, and is limited to individuals who are homebound.

Examples of allowable Home Health Care services include administration of intravenous and aerosolized drug therapy, routine diagnostics testing administered in the home, wound care, preventive and specialty care, and other medical therapies.

Service Limitations:

- Services cannot be provided to individuals living in nursing facilities or inpatient mental health or substance use treatment facilities.
- Services must relate to the client's HIV disease.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Type of service provided
- Date service was provided
- Signature of professional providing the service at each visit.

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving Home Health Care services. Supporting documentation is required and should be attached to the EFA application. Multiple Home Health Care services can be requested on one application. The use of the EFA application for Home Health Care Services is temporary while another Financial Assistance Application is being developed in REMI.

Service units of Home Health Care are documented per service provided (i.e., one payment equals one service unit) as "Home Health Care" in REMI or CAREWare with a corresponding dollar amount.

HOSPICE SERVICES

Hospice Services are end-of-life care services provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Examples of allowable Hospice Services include room, board, nursing care, counseling, physician services, and palliative therapeutics.

Service Limitations:

- Services cannot be provided to individuals living in skilled nursing facilities or nursing homes.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Type of service provided
- Date service was provided
- Location service was provided
- Physician certification of client's terminal illness
- Signature of professional providing the service at each visit

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving a Hospice service. Supporting documentation is required and should be attached to the EFA application. Multiple Hospice services can be requested on one application. The use of the EFA application for Hospice services is temporary while another Financial Assistance Application is being developed in REMI.

Service units of Hospice Services are documented per service provided (i.e., one payment equals one service unit) as "Hospice Services" in REMI or CAREWare with a corresponding dollar amount.

MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy activities must be pursuant to a medical provider's referral and based on a nutritional plan developed by a registered dietitian or other licensed nutrition professional. These activities can be provided in individual or group settings. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be documented under psychosocial support services.

Examples of allowable Medical Nutrition Therapy services include nutrition assessment and screening, dietary/nutritional evaluation, food and nutrition supplements per medical provider's recommendation, and nutrition education/counseling.

Referrals for Medical Nutrition Therapy services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the medical nutrition therapy

provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Type of service provided
- Frequency and duration of service provided
- Location of service provided
- Medical provider referral, if applicable
- Nutritional plan signed by the developing dietician, if applicable
- Client's diagnosed condition for which services are needed, if applicable
- Any follow up recommendations, if applicable
- Copy of Iowa License or Certificate for provider or providing agency receiving payment, if applicable.

Service units of Medical Nutrition Therapy are documented per service provided (i.e., one session equals one service unit) as "Medical Nutrition Therapy" in REMI or CAREWare with a corresponding dollar amount.

MENTAL HEALTH SERVICES

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

Referrals for Mental Health services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the mental health provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Treatment plan (see below for details)
- Copy of Iowa License or Certificate for provider or providing agency receiving payment

Treatment plans are required and must include:

- Diagnosed mental illness or condition
- Treatment modality (group or individual)
- Start date and projected end date
- Recommended number of sessions
- Any recommended follow up
- Signature of the developing provider.

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

ORAL HEALTH CARE

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

Referrals for Oral Health services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the oral health care provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Service Limitations:

- Outpatient services performed under general anesthesia are unallowable. Other funding sources may be available for these services. Please contact a Client Services Coordinator for more information.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Copy of Iowa License or Certificate for provider or providing agency receiving payment.

Service units of Oral Health Care are documented per service provided (i.e., one dental visit equals one service unit) as "Oral Health Care" in REMI or CAREWare.

OUTPATIENT/AMBULATORY HEALTH SERVICES

Outpatient/Ambulatory Health Services is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting, including clinics, medical offices, mobile vans, telehealth technology, and urgent care facilities. Services may be delivered by appropriately licensed agency staff or may be delivered by community providers through a voucher or direct payment arrangement. The delivery of outpatient/ambulatory services should be consistent with Public Health Service (PHS) guidelines concerning antiretroviral treatment for adults and adolescents, maternal to child transmission, and management of HIV complications.

Allowable Outpatient/Ambulatory Health Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and screening of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

Service Limitations:

- Services are provided as part of the treatment of HIV infection.
- Specialty medical care must relate to HIV infection and/or conditions arising from the use of HIV medications.
- Services cannot be provided in an emergency room, hospital, or other type of inpatient treatment setting.
- Visits to urgent care facilities are limited to HIV-related needs.

Referrals for Outpatient/Ambulatory Health Services (OAHS) should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the OAHS provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Any deviations from Public Health Service (PHS) guidelines should be justified by specific client circumstances and evidence-based medical practices.
- Verification that services were provided in an outpatient setting.
- Copy of Iowa License or Certificate for provider or providing agency receiving payment.

Service units of Outpatient/Ambulatory Health Services are documented per service provided (i.e., one visit equals one service unit) as "Outpatient/Ambulatory Health Services" in REMI or CAREWare.

SUBSTANCE ABUSE OUTPATIENT CARE

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

Allowable Substance Abuse Outpatient Care services include screening, assessment, diagnosis and treatment. Treatment includes pretreatment/recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, outpatient drug-free treatment/counseling, medication assisted therapy, neuro-psychiatric pharmaceuticals, and relapse prevention.

Service Limitations:

- Acupuncture therapy is only allowable as part of a substance use disorder treatment program and is documented in a treatment plan.
- Syringe access services are unallowable under current Iowa law.

Referrals for Substance Abuse Outpatient Care services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the substance abuse outpatient care provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- A financial assistance application

- Supporting documentation
- Treatment plan (see below for details)
- Copy of Iowa License or Certificate for provider or providing agency receiving payment
- Release of information, when applicable.

Treatment plans are required and must include:

- Quantity, frequency, and treatment modality
- Treatment start date and end date
- Details of acupuncture services, when applicable
- Regular monitoring and assessment of client progress
- Signature of the service provider.

A financial assistance application must be completed in REMI for all clients receiving a Substance Abuse Outpatient service. If services are being billed to the client's insurance, a Health Insurance Premium & Cost-Sharing Assistance application should be used. If services are not billed to the client's insurance, an Emergency Financial Assistance application should be used. Supporting documentation is required and should be attached to the financial assistance application. Multiple Substance Abuse Outpatient services can be requested on one application.

Service units of Substance Abuse Outpatient Care are documented per service provided (i.e., one visit equals one service unit) as "Substance Abuse Outpatient Care" in REMI or CAREWare with a corresponding dollar amount.

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SUPPORT SERVICES

CHILD CARE SERVICES

Child Care Services are the provision of care for the children of clients while the client attends medical or other appointments or Ryan White Program-related meetings, groups, or trainings. Use of these funds should be limited and carefully monitored. Such arrangements may raise liability issues for the funding source which should be carefully weighed by the Part B Provider.

Child Care Services may be provided by a licensed or registered child care provider or by an informal child care provider such as a neighbor, family member, or other person. If informal child care is utilized, a liability release form must be obtained that protects the client, provider, and the Ryan White program. Cash cannot be given to clients or primary caregivers to pay for these services.

Service Limitations:

- Services must be intermittent and provided only to permit the client to attend medical or other appointments or Ryan White Program-related meetings, groups, or trainings.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting Documentation
- Date and duration of service provided
- Frequency of service provided
- Type of appointment that made child care necessary
- Copy of Iowa License or Certificate for service provider, if applicable
- Liability release form, if applicable

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving a Child Care service. Supporting documentation is required and should be attached to the EFA application. Multiple Child Care services can be requested on one application. The use of the EFA application for Child Care services is temporary while another Financial Assistance Application is being developed in REMI.

Service units for Child Care Services are documented per service provided (i.e., one disbursement equals one service unit) as "Child Care" in REMI or CAREWare with a corresponding dollar amount.

EMERGENCY FINANCIAL ASSISTANCE

Emergency Financial Assistance (EFA) is the provision of short-term payments to agencies or the establishment of voucher programs intended to assist persons living with HIV with emergency expenses. Direct emergency financial awards are not entitlements. Emergency financial assistance is meant to be short term, when no other resources are available. It should NOT duplicate, and should be coordinated with, the assistance provided by the Iowa BDAP. Clients should be actively linked to long-term support, including health insurance, Medicaid, Medicare, HOPWA, and other available programs. Emergency

financial assistance may *not* be provided to clients in cash or cash equivalents (such as traveler's checks). No payment may be made directly to clients, family, or household members.

Examples of allowable Emergency Financial Assistance services include essential utilities, health insurance premiums, co-pays, deductibles, co-insurance, medications, food, essential household supplies, transportation, and other services as approved by the Iowa RWPB Program.

The following housing related expenses previously provided through Ryan White Housing funds should now be paid out of Emergency Financial Assistance (EFA); one-time rent and/or utility expenses, temporary hotel stays, first month's rent, one-time fees (rental application, background check, utility activation, etc.), and other one-time housing services approved by the Iowa RWPB Program. These services should be requested on an EFA application and do NOT require housing goals.

Service Limitations:

- Continuous provision of an allowable service must not be funded through EFA.
- Outpatient services performed under general anesthesia are unallowable. Other funding sources may be available for these services. Please contact a Client Services Coordinator for more information.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting Documentation

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving an EFA service. Supporting documentation is required and should be attached to the EFA application. Multiple EFA services can be requested on one application.

Service units for Emergency Financial Assistance (EFA) are documented per service provided (i.e., one disbursement equals one service unit) as "EFA/RWB" or "EFA/Utilities/RWB" or "EFA/Cell & Internet/RWB" or "EFA/Housing/RWB" or EFA/Medical/RWB" in REMI or CAREWare with a corresponding dollar amount.

FOOD BANK/HOME-DELIVERED MEALS

Food Bank/Home-Delivered Meals involve the provision of actual food or meals. It does not include finances to purchase food or meals, but it may include vouchers to purchase food. Clients will be made aware of service limitations (see below) when provided a gift card or voucher. The provision of essential household supplies, such as hygiene items and household cleaning supplies, should be included in this service category. Nutritional supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed dietician should be included in food bank expenditures.

The Part B provider shall adhere to all federal, state, and local public health food safety regulations to ensure the health and safety of clients. The program must meet all requirements of the local health department for food handling and storage, and must maintain record of health department inspections.

Part B providers will obtain appropriate licensure/certification for maintaining a food bank where required under State or local regulations.

Examples of allowable Food Bank/Home-Delivered Meals include food items, hot meals, food gift cards or vouchers, nutritional supplements, household supplies, hygiene products, and laundromat tokens or vouchers.

Service Limitations:

- Purchase of alcohol, tobacco, illegal drugs, or firearms is prohibited
- Vouchers may not be redeemed for cash.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Current licensure/certification, if applicable
- Record of health department inspections, if applicable.

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

HEALTH EDUCATION AND RISK REDUCTION

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

Examples of allowable Health Education and Risk Reduction services include education on PrEP, treatment as prevention, health care coverage options, health literacy, treatment adherence, and CLEAR (Choosing Life: Empowerment, Actions, Results) counseling.

Service Limitations:

- Services cannot be delivered anonymously.

Service units for Health Education and Risk Reduction services are documented per service provided (i.e., one encounter equals one service unit) as "Health Education and Risk Reduction" or "CLEAR" in REMI or CAREWare.

HOUSING SERVICES

Housing Services are the provision of payments to support people living with HIV to obtain, secure, and/or maintain adequate housing. Housing assistance is meant to be short term, when no other resources are available. It should NOT duplicate, and should be coordinated with, the assistance provided by the Housing Opportunities for Persons with AIDS (HOPWA) program. Assistance should support housing options that are feasible for the client to sustain beyond support provided through Ryan White funding.

Examples of allowable Housing Services include rent, past-due rent, lot rent, ongoing utility assistance including cell phone and internet (e.g., more than two consecutive months or more than two months of assistance in a six-month period), and other housing services as approved by the Iowa Ryan White Part B (RWPB) Program.

The following housing related expenses should now be paid out of Emergency Financial Assistance (EFA); one-time rent and/or utility expenses, temporary hotel stays, first month's rent, one-time fees (rental application, background check, utility activation, etc.), and other one-time housing services approved by the Iowa RWPB Program. These services should now be requested on an EFA application and do NOT require housing goals.

Service Limitations:

- Funds are limited to a 24-month cap that resets after three years of ineligibility.
- Funds cannot be used for rental deposits, utility deposits, mortgage payments, or property taxes.
- Funds may *not* be provided to clients in cash or cash equivalents (such as traveler's checks).
- No payment may be made directly to clients, family, roommates, or household members.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Housing Assistance application
- Supporting documentation
- Active housing plan/goal
- Evidence of tenancy.

A Housing Assistance application must be completed in REMI for all clients receiving Housing Services. Supporting documentation is required and should be attached to the Housing Assistance application. Multiple Housing services can be requested on one application.

An active housing plan must include:

- Sustainable short-term and/or long-term goals for alleviating risks of a lack of housing, establishing affordable permanent housing stability, and improving access to health care and supportive services
- Identification of barriers to sustainable housing
- Action steps to address barriers and housing needs
- Referral(s) to other available housing support services when appropriate
- Budget

Service units for Housing Services are documented as "Housing Services/RWB" or "Housing Services/Utilities/RWB" or "Housing/Cell & Internet/RWB" in REMI or CAREWare with a corresponding dollar amount.

The "Housing Services/RWB" service is the only service that counts towards the client's 24-month cap.

LINGUISTIC SERVICES

Linguistics Services include the provision of interpretation and translation activities which can be conducted in-person, over the phone, or virtually. These activities are to be provided when such services are necessary to facilitate communication between the provider and client or to support delivery of other Ryan White allowable services. Part B providers must assure the competence of language assistance provided to clients limited in English proficiency by interpreters and bilingual staff. Family and friends should not be used to provide translation services, except on request by the client. If a client chooses to have a family member or friend as their interpreter, the provider must obtain a written and signed consent. The family member or friend must be able to communicate fluently in both English and the native language of the client.

Service Limitations:

- Services must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS): https://thinkculturalhealth.hhs.gov/clas.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Type of service —oral interpretation or written translation
- Language involved
- State and/or local certification for interpreters/translators
- Evidence of compliance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- Resume demonstrating bilingual proficiency and training on the skills and ethics of interpreting for bilingual staff who provide interpretation or translation services, if applicable
- Consent form signed by the client for family/friend providing interpretation, if applicable.

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

MEDICAL TRANSPORTATION SERVICES

Medical Transportation Services are services provided directly or through a voucher to a client so that he or she may access HIV-related medical and support services. Transportation needs should be assessed on a regular basis to eliminate barriers to accessing services. The type of transportation best suited to the needs of the client should be used while ensuring safety and cost-effectiveness.

Examples of allowable Medical Transportation Services include the use of agency vehicles, mileage reimbursement, taxi vouchers, Uber, UberHealth, bus tokens, bus passes, gas cards, and volunteer drivers where insurance and liability issues are addressed.

Service Limitations:

- Funds cannot be used for expenses related to personal vehicles including maintenance, car loan payments, car lease payments, car insurance, and car registration.

- The purchase of an agency vehicle requires pre-approval. In addition, subrecipients shall report annually on capital assets purchased with Ryan White Part B funding that have a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Reason for trip and its relation to accessing health and support services
- Trip origin and destination
- Method of transportation used
- Evidence of valid driver's license for all staff and volunteers providing direct transportation
- Evidence of vehicle liability insurance for vehicles used to provide services
- Evidence of Iowa vehicle registration for vehicles used to provide services.

Service units are defined as an instance when a client receives vouchers, gas cards, payments to an outside vendor, bus tokens, or transportation delivered by agency staff or volunteers. It should be documented as "Medical Transportation" in REMI or CAREWare with a corresponding dollar amount, if applicable. If staff time is used to transport a client, the service should be entered in the category in which that staff member is funded, and 15-minute increments should be used.

OTHER PROFESSIONAL SERVICES

Other Professional Services include the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities.

Examples of allowable Other Professional Services include legal services, permanency planning, income tax preparation, assistance with public benefits such as Social Security Disability, preparation of living wills and powers of attorney.

Service Limitations:

- Funds cannot be used for criminal defense or class action suits unrelated to access to services eligible for under Ryan White.

Referrals for Other Professional Services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the other professional services provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Description of how services are necessitated by the client's HIV status
- Type of service provided and hours spent in the provision of such service.

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving Other Professional Services. Supporting documentation is required and should be attached to the EFA application. Multiple Other Professional Services can be requested on one application. The use of the EFA application for Other Professional Services is temporary while an Other Financial Assistance Application is being developed in REMI.

Service units for other professional services are documented in 15-minute increments as "Other Professional Services" in REMI or CAREWare.

OUTREACH SERVICES

Outreach Services focus on identifying PLHIV who do not know their status or who know their status but are not in care. These activities often occur outside of the traditional care and treatment setting. Outreach services prioritize populations who are at risk of, or have fallen out of care, with the purpose of maintaining, connecting, or re-connecting people to medical care and case management services. Education is an important part of outreach services and should include the importance of accessing and maintaining HIV care, the availability of HIV medical care, the importance of adhering to HIV medications, the availability of Ryan White services, and preventing the transmission of HIV.

Referrals for Outreach Services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the outreach services provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

The following components are required:

- Services must target populations and places that have a high probability of reaching PLHIV who have never been tested, are undiagnosed, have been tested but not received their test results, or know their status but are not in medical care.

- Services must be conducted at times and in places with a high probability of identifying PLHIV and/or people exhibiting high-risk behaviors.
- Services must target populations known to be disproportionately at risk for HIV infection.
- Services must be provided in coordination with load and state HIV prevention programs to avoid duplication of effort.

Service Limitations:

- Services cannot be delivered anonymously.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- The design, implementation, target areas, times, populations, and outcomes of outreach activities.
- The number of individuals reached, referred for testing, found to be positive, referred to care and entered care.
- Understanding with other outreach service providers should be on file, if applicable

Service units of outreach services are documented in 15-minute increments as "Outreach" in REMI or CAREWare.

PSYCHOSOCIAL SUPPORT SERVICES

Psychosocial Support Services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling for PLHIV. This service includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements. Psychosocial support services help clients empower themselves, and develop effective strategies for living healthy lives. Through one-on-one interactions and in small groups, these services support a client's engagement in health care and provide opportunities for education, skills building, and emotional support in a respectful environment.

Service Limitations:

- Funds cannot be used for social/recreational activities or gym memberships
- Pastoral counseling must be available to all eligible individuals regardless of their religious denominational affiliation.

Referrals for Psychosocial Support Services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the psychosocial support provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments

- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Copy of licensure or accreditation for provider or providing agency, if applicable
- Types of activities provided

Service documentation for one-on-one activities must include:

- Date and duration (service units)
- General topics discussed
- Activities conducted
- Goals and objectives achieved during individual session
- Referrals made
- A case note and corresponding service unit will be entered in REMI or CAREWare.

Service documentation for group activities must include:

- Dated sign-in sheet
- Number of participants attended
- Name and title of group facilitator
- Location of group
- Copies of materials or handouts
- Summary of topics discussed
- Activities conducted
- Goals and objectives achieved during group session
- A case note and corresponding service unit will be entered in REMI or CAREWare stating the client participated in a psychosocial support group.

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

REFERRAL FOR HEALTH CARE AND SUPPORTIVE SERVICES

Referral for Health Care and Supportive Services direct a client to services in person or through telephone, written, or other type of communication. Referrals under this category are generally made by support staff. Referrals made by case managers are documented in the appropriate tier of case management. Referrals should be appropriate to the client's situation, lifestyle, and needs, and should include the referral agency name, address, phone number, and contact person. As appropriate, releases of information should be obtained to permit communication about the client's needs and other

important information to the referral agency. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Examples of common referrals include Medicaid, Medicare, pharmacy assistance programs, and local social service agencies. Part B agencies are encouraged to develop and maintain a comprehensive referral list for a full range of service providers.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients to gather required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Service Limitations:

- Funds cannot duplicate referral services provided through other service categories such as MCM, non-MCM, or Outpatient/Ambulatory Health Services.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Date of service
- Type of referral
- Follow up provided.

Service units of Referral for Health Care/Supportive Services are documented in 15-minute increments as "Referral for Health Care" in REMI or CAREWare.

REHABILITATION SERVICES

Rehabilitation Services are the provision of HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Examples of allowable Rehabilitation Services include physical, occupation, speech, and vocational therapies.

Service Limitations:

- Must be provided by a licensed or authorized professional on an outpatient basis
- Services provided in long-term care facilities, nursing homes, or inpatient hospitals are unallowable.

Referrals for Rehabilitation Services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the rehabilitation service provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Type of service and type of facility
- Dates, duration, and location of services
- Copy of provider licensure.

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving Rehabilitation Services. Supporting documentation is required and should be attached to the EFA application. Multiple Rehabilitation Services can be requested on one application. The use of the EFA application for Rehabilitation Services is temporary while an Other Financial Assistance Application is being developed in REMI.

Service units for Rehabilitation Services are documented in 15-minute increments as "Rehabilitation Services" in REMI or CAREWare.

RESPITE CARE SERVICES

Respite Care Services is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for clients in order to temporarily relieve their primary caregiver responsible for their day-to-day care.

Service Limitations:

- Recreational and social activities are only allowable in a licensed or certified setting.
- Funds cannot be used to pay for a client's gym membership.
- Informal, home-based care is allowable when liability issues have been carefully considered.
- Cash payments to informal caregivers is unallowable.

Referrals for Respite Care Services should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the respite care provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients in gathering required documents to bring to the appointment.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Emergency Financial Assistance application
- Supporting documentation
- Date and duration of services
- Setting/method of services
- Copy of provider licensure
- Evidence that liability issues have been addressed when informal services are used.

An Emergency Financial Assistance (EFA) application must be completed in REMI for all clients receiving Respite Care Services. Supporting documentation is required and should be attached to the EFA application. Multiple Respite Care Services can be requested on one application. The use of the EFA application for Respite Care Services is temporary, while an Other Financial Assistance Application is developed in REMI.

Service units for Respite Care Services are documented in 15-minute increments as "Respite Care Services" in REMI or CAREWare.

SUBSTANCE ABUSE SERVICES—RESIDENTIAL

Substance Abuse Services—Residential is the provision of medical or other treatment and/or counseling to address substance abuse problems (e.g., alcohol and/or legal and illegal drugs) in a residential setting and include screening, assessment, diagnosis, and treatment of substance use disorder. Substance Abuse Services—Residential is only permitted when the client has received a written referral from a clinical provider as part of a substance use disorder treatment plan. Ryan White agencies should work closely with the Iowa RWPB Client Services staff to determine client eligibility and ensure availability of funds.

Examples of allowable Substance Abuse Services—Residential include pretreatment/recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, medication assisted therapy (MAT)/medication for opioid disorder (MOUD), neuro-psychiatric pharmaceuticals, relapse prevention, detoxification—if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical psychiatric hospital). Acupuncture may be an allowable cost under this service category when it is included in a documented plan as part of a substance use disorder treatment program.

Service Limitations:

- A written referral from a clinical provider is required.

- Acupuncture therapy is only allowable as part of a substance use disorder treatment program and is documented in the treatment plan.
- Service must be provided in a short-term residential setting.
- Service must be provided under the supervision of a physician or other qualified personnel.

Referrals for Substance Abuse Services—Residential should include agency name, contact person, address, and phone number. As appropriate, releases of information should be obtained to permit provision of information about the client's needs and other important information to the substance abuse services provider. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process should also include:

- Facilitating a warm hand-off with the inpatient facility
- Initiating regular follow-up with the inpatient facility regarding the client's status, needs, and anticipated release date
- Ensuring the client has access to basic needs upon release from the inpatient facility.

Best Practice: Document referrals, follow-up activities, and outcomes using the *Referrals* feature in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

Service documentation must include:

- Pre-Authorization for Medical Services Financial Assistance application
- Supporting documentation
- Treatment plan (see below for details)
- Written referral made by a clinical provider
- Copy of Iowa License or Certificate for providing agency receiving payment
- Release of information, when applicable.

Treatment plans are required and must include:

- Quantity, frequency, and treatment modality
- Treatment start date and end date
- Details of acupuncture services, when applicable
- Regular monitoring and assessment of client progress.

A Pre-Authorization for Medical Services Financial Assistance application must be completed in REMI and submitted to the Iowa RWPB Program for approval for all clients receiving Substance Abuse Services—Residential. Supporting documentation is required and should be attached to the Pre-Authorization for Medical Services Financial Assistance application.

Service units for Substance Abuse Services—Residential are documented per service provided (one unit per admittance) as "Substance Abuse: Residential" in REMI or CAREWare with a corresponding dollar amount.

IOWA HHS

OTHER IOWA PROGRAMS

DELTA DENTAL INSURANCE PROGRAM

The **Delta Dental Insurance Program** provides dental insurance to Iowans living with HIV who do not have dental insurance or their current coverage does not provide access to needed oral health services.

The program offers two comprehensive plans: Preventive and Preferred.

The Delta Dental paper application requires the following information:

- Policy holder information—name, address, phone, email
- Requested effective date
- Plan choice
- Birthdate
- Sex
- Other dental coverage details
- Social Security number—**optional**.

Completed applications are submitted via secure email to the BDAP office **and** to Delta Dental customer service. Applications are typically processed within 24-48 hours, and clients receive their benefit documents and ID card within 5-10 business days after approval. Applications should be uploaded into the client's chart in REMI. A copy of the Delta Dental Application can be found in Appendix F.

Premium invoices are mailed directly to the Iowa RWPB Program and processed for payment through NuCara. NuCara will enter services in CAREWare when premium payments are made.

Service Limitations:

- Clients must be enrolled in case management at a tier level of BCM or higher.

When a client is no longer eligible for services or has access to other dental insurance, a Department of Public Health Change Request Form needs to be completed and submitted via secure email to the BDAP office and to Delta Dental customer service. A copy of the Department of Public Health Change Request Form can be found in Appendix G.

TOBACCO USE CESSATION PROGRAM

Tobacco Use Cessation Program provides assistance in obtaining resources commonly used for smoking cessation. This service includes the provision of prescription or over-the-counter tobacco use cessation aids, assistance in accessing services provided by Quitline Iowa, and brief counseling and support within the case management structure. Most individuals who attempt tobacco use cessation will relapse several times before achieving long term success, and research has shown that a combination of medicinal aids and counseling is far more effective than either intervention alone. The case manager should maintain regular contact with the client and support tobacco use cessation efforts. Tobacco use cessation will improve clients' overall health and ability to achieve HIV care goals, reduce financial strain, and foster self-respect and a sense of achievement.

Service Limitations:

- Clients enrolled in BDAP should access these products through the BDAP program.

Referrals for Tobacco Use Cessation services should include agency name, contact person, address, and/or phone number. As appropriate, releases of information should be obtained to permit the sharing of information with the provider of tobacco cessation services. Follow up is an essential part of the referral process and should occur promptly in effort to identify and address any barriers to accessing services.

Referral process may also include:

- Assisting clients with making and keeping appointments
- Identifying referral agency eligibility requirements
- Assisting clients to gather required documents to bring to the appointment.

Best Practice: Goals specific to tobacco cessation are created in REMI.

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

For Ryan White Part B clients not on BDAP

A Tobacco Cessation application must be completed in REMI. Multiple products may be requested on one application. Supporting documentation is required and should be attached to the Tobacco Cessation application. NuCara will enter services in CAREWare when products are provided.

The Tobacco Cessation application requires the following client information:

- Name, address, phone, email
- Income information
- Insurance
- Prescribing medical provider name and number
- Requested products
- Pharmacy where prescriptions will be filled.

For Ryan White Part B client on BDAP

Tobacco cessation products can be accessed through the BDAP pharmacy, NuCara, so a Tobacco Cessation application is not required. A prescription for the requested product(s) should be provided to NuCara. NuCara will contact the client to discuss the product(s) prior to mailing or having the client pick them up. NuCara will enter services in CAREWare when products are provided.

NALOXONE PROGRAM

The Naloxone Program provides assistance in obtaining Naloxone (Narcan), a prescription medication used to reverse the effects of an opioid overdose. A prescription is NOT required for Naloxone in Iowa. Naloxone is provided through NuCara Pharmacy and is available to eligible Ryan White Part B clients, Ryan White Part C clients, and support persons on the client's behalf.

Service Limitations:

- Clients enrolled in BDAP should access these products through the BDAP program.
- A current Release of Information must be on file in order for a support person to obtain Naloxone on behalf of the client.

The case manager or nurse care manager will have the client initial the Naloxone Eligibility Assessment (Appendix H) and complete the Naloxone Application (Appendix I). The Naloxone Application is not required for clients on BDAP. The client or support person is then provided with the Narcan Patient Information Handout. The Eligibility Assessment and Naloxone Application are submitted via secure email or fax to NuCara Pharmacy **and** the Iowa RWPB Program. These documents should be uploaded into the client's electronic file.

The pharmacist at NuCara will call the client or client's support person to complete the required Eligibility Assessment. NuCara will default to filling the nasal option of Naloxone unless the client requests the injectable. Naloxone can be mailed to the client or picked up at the NuCara.

The case manager enters "Naloxone/RWB" service in REMI or CAREWare for clients not on BDAP. NuCara will enter service in CAREWare for clients on BDAP.

CELL PHONE & INTERNET ASSISTANCE PROGRAM

The Cell Phone & Internet Assistance Program provides assistance in obtaining basic cell phone OR internet services that are needed for the client to maintain HIV medical and/or supportive services. Assistance can be provided through Emergency Financial Assistance if the need is one time or short-term (e.g., no more than two consecutive months or no more than two months of assistance in a six-month period). If assistance is needed for a longer period of time, it can be provided through Housing Services.

In order to comply with HRSA requirement of payer of last resort, case managers should assist clients in obtaining eligibility for other programs prior to utilizing Ryan White Part B funds. Many programs offer free government cell phones and minutes, so case managers need to become familiar with resources in their community. Examples of potential assistance with cell phone or internet include:

- Internet assistance through the Affordable Connectivity Program at https://www.fcc.gov/acp.
- Cell phone assistance through programs such as Iowa Lifeline Free Government Phone Program

Service Limitations:

- Maximum amount of assistance that can be paid towards a cell phone or internet bill is $70/month (not including taxes and fees).
- Funds cannot be used to pay for high-end cell phone and internet packages that provide beyond what is needed to ensure client access to medical and support services.
- Funds cannot be used to pay for multiple phone lines, cell phone payment installments, insurance, or additional apps and add-ons such as gaming packages, Spotify, etc.
- Funds cannot be used to pay for cell phone or internet services for the sole purpose of work-related activities or job searching.
- Funds cannot be used to pay for a smartphone and internet for the same client as the smartphone should have internet capabilities (exceptions can be requested from CSCs).

Documentation must be maintained for each client served. Records should be complete, accurate, confidential, and secure, and will reflect compliance with the standards outlined in this manual.

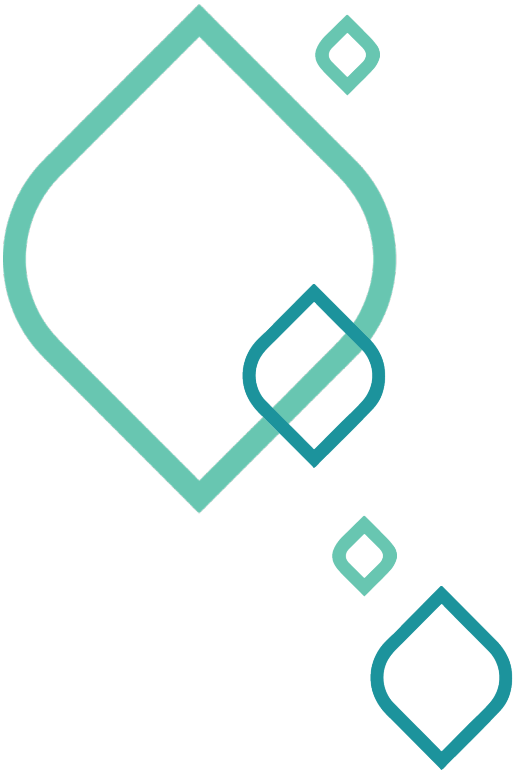
Service documentation must include:

- Emergency Financial Assistance application **or** Housing Services application
- Supporting documentation
- Active housing plan/goal **if** paid through Housing Assistance.

An Emergency Financial Assistance (EFA) application or a Housing Services application must be completed in REMI for all clients receiving cell phone or internet assistance through EFA or Housing. Supporting documentation is required and should be attached to the EFA or Housing application.

Service units for Cell Phone and Internet Assistance are documented per service provided. The case manager enters "EFA/Cell & Internet/RWB" or "Housing/Cell & Internet/RWB" service in REMI or CAREWare.

DOCUMENTATION & FILE MAINTENANCE



IOWA HHS

THE RYAN WHITE ELECTRONIC MANAGEMENT INFORMATION SYSTEM (REMI)

The Ryan White Electronic Management Information (REMI) System is a secure, centralized, online platform that serves as the client's case management file. All program forms are located in REMI in an electronic format. All eligibility determination documentation/verification are required to be uploaded to the client's profile in REMI.

The REMI System is only for clients enrolled in Iowa Ryan White Part B case management services. Clients who receive Ryan White Part B services at a Part B subrecipient agency but are case managed at a different agency should have their information entered in CAREWare, not REMI. No Ryan White Part C services should be entered into REMI.

If you need access to REMI, complete the New User Form—External User and email it to the Ryan White Data Coordinator.

REMI DATA ENTRY POLICY

Part B subrecipients are required to complete the client profile fields listed below in the REMI Required Client Profile Fields section within 10 business days after initial enrollment into case management and after changes are reported by the client.

Part B subrecipients are required to enter all services and case notes within 3 business days of the date of the service.

Please see the CAREWare Data Entry Policy for guidance on entering information for clients who are enrolled in case management at another Part B subrecipient agency.

REMI REQUIRED CLIENT PROFILE FIELDS

The following client profile fields are required to be completed in REMI. An * indicates that the field is NOT imported into CAREWare (see the REMI-CAREWare Interface section for more details).

Demographics Tab

- First name (must be legal first name)
- Last name (must be legal last name)
- Date of birth
- Gender
- Sex at birth
- URN
- Case manager*
- Race
    - Race subgroup (if applicable)
- Ethnicity
    - Ethnicity subgroup (if applicable)
- Primary language*
- Country of origin*
- Status in the US*

Contact Info Tab

- Residential address (if homeless, not required—please document)
  - Street (no PO Box)
  - City
  - County
  - Zip Code
  - Housing Status
  - Allowed to visit?*
- Mailing address
  - Street
  - City
  - County
  - State
  - Zip Code
  - Allowed to send mail?*
- Cell phone number (if none, not required)
  - Allowed to call?*
  - Allowed to leave message?*
  - Allowed to text?*
  - Mobile commons release?*
- Home phone number (if none, not required)
  - Allowed to call?*
  - Allowed to leave message?*
- Email address (if none, not required)
  - Allowed to email?*
- Preferred method of contact*
- Emergency contact (if none, not required)*
  - Emergency contact name*
  - Relationship to client*
  - Aware of status?*
  - Emergency contact phone number (if none, not required)*
  - Emergency contact email address (if none, not required)*
  - Emergency contact address (if none, not required)*

Clinical Info Tab

- HIV diagnosis date
- Received an AIDS diagnosis?
- AIDS diagnosis date (if not diagnosed with AIDS, not required)

- HIV/AIDS status
- Mode of exposure (select all of the following categories that apply)
    - *Males who have sex with male(s)* should be checked when a male client indicates sexual contact with other men. This should be checked regardless of sexual orientation (e.g., if the client identifies as heterosexual but reports having sex with men).
    - *Person who injects drugs (PWID)* should be checked when the client reports the use of intravenous drugs.
    - *Hemophilia/coagulation disorder* should be checked when the client has been diagnosed with a blood clotting disorder and was infected as a result of having this disorder.
    - *Heterosexual contact* should be checked when a client reports sexual contact with a person of the opposite sex who is HIV+ or is at an increased risk of HIV infection.
    - *Perinatal Transmission* should be checked when a client was infected while in the mother's womb during gestation or during birth. This should also be selected if the client is under the age of 2, and the HIV status is still undetermined.
    - *Receipt of transfusion of blood, blood components, or tissue* should be checked when the client was the recipient of a tainted blood or tissue product that resulted in their HIV diagnosis.
    - *Not reported or not identified* should not be checked if at all possible as it will be identified as an error on reports. The next best option should be selected instead of this one.
- HIV medical clinic
- Tobacco user
- Co-infected with hepatitis C?*

Medications/Pharmacy Tab

- Is NuCara Specialty Pharmacy in-network with the client's insurance?*
- Name of in-network pharmacy*
- Phone number*
- Address*
- Category (if not prescribed medications, not required)*
- Medication name (if not prescribed medications, not required)*

Insurance

- Insurance coverage types

Income/Household Tab

- Marital status*
- Sources of income
    - All associated income subsections/cards
- Additional household members (if applicable)
    - First name*
    - Last name*
    - Relationship*
    - Aware of client's HIV status?*

- Count toward Ryan White eligibility?*
- Income verification required?*
- Sources of income
    - All associated income subsections/cards

Uploads Tab

- HIV/AIDS Diagnosis Verification
    - Required to be uploaded at the time of enrollment
- Residence Verification
    - Required to be uploaded annually
- Income Verification
    - Required to be uploaded annually

REMI SERVICES AND CASE NOTES

Ryan White services are tracked and reported by each Part B subrecipient. Part B subrecipients are required to enter all Ryan White Part B services and case notes in REMI for clients enrolled in case management at their agency. Please see the CAREWare Services and Case Notes section for guidance on case note and service entry for Part B clients enrolled in case management at another Part B subrecipient agency.

Each funded service is listed in the Services tab of the Case Notes & Services module in REMI. The Iowa RWPB Program is responsible for maintaining the list of available services in REMI. Service units are reported in 15-minute increments OR as a one-time service, based on the service provided. Please see the Ryan White service standard for the correct way to enter it in REMI.

The following fields are required in REMI when entering a service:

- Service name
- Contract
- Service provider (select everyone who provided the service)
- Service date
- Units
- Cost (if no associated cost, not required).

Only one entry of each service type may be added to REMI per day. In other words, please add units to the existing service if provided more than once in a day. Example: A client calls in the morning and in the afternoon. Instead of adding two separate services in REMI, add units to the existing service from the morning.

In some cases, services may be batch entered from a single invoice serving as supporting documentation for multiple clients. When this occurs, the subrecipient agency must notify the Iowa RWPB Program and collaborate in the creation of a "Batch" financial assistance service. When the batch invoice is entered into REMI, the "Batch" service must be used. Financial Assistance Applications in REMI are not required for batch-entered services. However, the subrecipient agency must retain the invoices and provide them to the Iowa RWPB Program as supporting documentation when requested. Batch service entry is also exempt from the 3-day data entry policy, but must inform the Iowa RWPB Program as to how frequently services will be entered (may not be less than once a month).

Along with the service, a case note must be entered. The case note provides a narrative format for Part B subrecipients to document details of the service provided. Case notes can only be viewed by the Part B subrecipient who entered the note and the Iowa RWPB Program. The following fields are required in REMI when entering a case note:

- Case note
- Case note date.

Please note that the case note author is auto-generated by REMI and reflects the user entering the case note.

Unlike services, more than one case note may be entered per day in REMI. Each service entry must have a corresponding case note. Services and case notes must be entered within three business days of the service date.

Assessment Narrative Case Notes

All annual assessments must be accompanied by a narrative case note. The case note should summarize the client's situation at the time of the assessment and include the following applicable topics:

- Income/Household
- Housing
- Transportation
- HIV Medical Care
- General Medical / Gender-Specific Health
- Sexual Health
- Hepatitis C
- Vision
- Oral Health
- Nutrition and Wellness
- Mental Health
- Substance Use Management
- Legal
- Support System.

There are two tools in the REMI annual assessment that assist with the creation of a narrative case note:

- **Template Case Note section:** This section of the assessment provides a basic case note for the case manager to expand upon. Please note that the template case note does not contain all of the detail required for the narrative case note. Instead, its purpose is to provide a foundation for the case manager to build upon. The text in this section of the assessment must be copied and pasted into a case note (i.e., the case manager cannot edit the case note inside of the assessment).
- **Summary Case Note section:** This displays the text entered in each assessment section's *Case Note* field. The summary case note section may not contain all of the detail required for the narrative case note, so the case manager may need to add more information to it. The text in this section of the assessment must be copied and pasted into a case note (i.e., the case manager cannot edit the case note inside of the assessment).

Case Notes for Financial Services

When financial assistance is provided to a client, the case note should include the type and the amount of the service. If more than one payment was made, then the case note should itemize the payments. Example: Two utility bills were paid for a client using Emergency Financial Assistance, one for $25 and another for $75. An Emergency Financial Assistance service was entered for 1 unit and $100. The case note should specify that two payments were made, their amounts, and the vendors that were paid.

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CAREWARE

CAREWare is an online software program created by jProg (Jeff's Programming Shop) for use by Ryan White HIV/AIDS Programs throughout the US. The Iowa instance of CAREWare is a secure, centralized, online platform designed to report client-level data from HIV programs funded through Ryan White Part B and Part C. The Iowa instance of CAREWare is used to report information about clients served by subrecipients funded through the Iowa RWPB Program. This section is meant as a brief overview. Please refer to the CAREWare User Guide for detailed procedures regarding CAREWare.

CAREWare Version 6 User Guide: If you need access to CAREWare, please complete the New User Form—External User and email it to the Ryan White Data Coordinator.

All Part B subrecipients are required to utilize CAREWare to track and report client-level data. There are several ways information can be entered into CAREWare:

- Data can be imported from REMI to CAREWare (for case managed clients only). Please see the REMI-CAREWare Interface section for more information on the nightly import.
- Data can be manually entered into CAREWare.
- Data can be imported from other data systems into CAREWare (e.g., electronic health records).

The remainder of this section will focus on the requirements of data manually entered into CAREWare or imported from data systems other than REMI. In other words, the following are requirements for clients who receive Part B services at the subrecipient agency, but who receive case management at another subrecipient agency.

CAREWARE DATA ENTRY POLICY

Part B subrecipients are required to complete the client profile fields listed in the CAREWare *Required Fields* section within 10 business days after initial enrollment into case management and after changes are reported by the client.

Part B subrecipients are required to enter all services and case notes within 3 business days of the date of service.

CAREWARE REQUIRED FIELDS

The following client profile fields are required to be completed in CAREWare.

Demographics Page

- First name (must be legal first name)
- Last name (must be legal last name)
- Date of birth
- Gender
- Sex at birth
- Residential address (if unhoused, not required—please document)
    - City
    - State
    - Zip code
    - County

- Phone number (If none, not required)
- Race
    - Any subgroups that may apply
- Ethnicity
    - Any subgroups that may apply
- HIV mode of exposure (select all of the following categories that apply)
    - Males who have sex with male(s) should be checked when a male client indicates sexual contact with other men. This should be checked regardless of sexual orientation (e.g. if the client identifies as heterosexual but reports having sex with men).
    - Injection drug user (IDU) should be checked when the client reports the use of intravenous drugs.
    - Hemophilia/coagulation disorder should be checked when the client has been diagnosed with a blood clotting disorder and was infected as a result of having this disorder.
    - Heterosexual contact should be checked when a client reports sexual contact with a person of the opposite sex who is HIV+ or is at an increased risk of HIV infection.
    - Perinatal Transmission should be checked when a client was infected while in the mother's womb or during birth. This should also be selected if the client is under the age of 2, and the HIV status is still undetermined.
    - Receipt of transfusion of blood, blood components, or tissue should be checked when the client was the recipient of a tainted blood or tissue product that resulted in their HIV diagnosis.
    - "Not reported" or "Not identified" should **not** be checked if at all possible, as it will be identified as an error on reports. Instead, **please select the next best option**.
- Enrollment status
- Enrollment date
- Vital status
- Case closed date (if applicable)
- Date of death (if applicable)
- Eligibility status
    - Eligibility date
    - Is eligible
    - Funding source
- HIV status
- HIV diagnosis date
- AIDS diagnosis date (if applicable)

Please note that while the Common Notes are not required, they *are* shared across all providers that serve the client. Common Notes should only include information that all providers need to know. Common Notes are often used to communicate information between the Ryan White Provider and the BDAP office.

Annual Review Page

- Insurance assessments
    - Insurance assessment date
    - Primary insurance
    - Other insurance (if applicable)
- Poverty level assessments
    - Date
    - Household size
    - Household income
- Housing assessments
    - Date
    - Type
    - Result

CAREWARE SERVICES AND CASE NOTES

Ryan White services are tracked and reported by each Part B subrecipient. Part B subrecipients are required to enter all Ryan White Part B services and case notes in CAREWare for clients who receive Part B service from their agency but the client is enrolled in case management at another subrecipient agency. Please see the REMI Services and Case Notes section for guidance on case note and service entry for clients who receive case management services at their agency.

Each funded service is listed in the Services page in CAREWare. The Iowa RWPB Program is responsible for maintaining the list of available Part B services in CAREWare. Service units are reported in 15-minute increments OR as a one-time service, based on the service provided. Please see the Ryan White service standard for the correct way to enter it in CAREWare.

The following fields are required in CAREWare when entering a service:

- Date
- Service name
- Contract
- Units
- Price (if no associated cost, not required)

Only one entry of each service type may be added to CAREWare per day. In other words, please add units to the existing service if provided more than once in a day. Example: A client calls in the morning and in the afternoon. Instead of adding two separate services in CAREWare, add units to the existing service from the morning.

Along with the service, a case note must be entered. The case note provides a narrative format for Part B subrecipients to document details of the service provided. Case notes can only be viewed by the Part B subrecipient who entered the note and the Iowa RWPB Program. The following fields are required in CAREWare when entering a case note (see next page).

Fields required in CAREWare when entering a case note:

- Date
- Author
- Case note.

Unlike services, more than one case note may be entered per day in CAREWare. Each service entered must have a corresponding case note. Services and case notes must be entered within three business days of the service date.

CASE NOTES FOR FINANCIAL SERVICES

When financial assistance is provided to a client, the case note should include the type and the amount of the service. If more than one payment was made, then the case note should itemize the payments. Example: Two utility bills were paid for a client using Emergency Financial Assistance, one for $25 and another for $75. An Emergency Financial Assistance service was entered for 1 unit and $100. The case note should specify that two payments were made, their amounts, and the vendors that were paid.

REMI-CAREWARE INTERFACE

A nightly import is set up to bring information from REMI to CAREWare. Please see the REMI *Required Client Profile Tabs/Fields* section for the fields that are imported into CAREWare after hours each night. In addition to the fields listed in the REMI Required Client Profile Fields section, all case notes and services are included in the nightly imports.

Every other week, viral load and CD4+ cell count results are imported from CAREWare to REMI. A client must have a completed Case Management Enrollment and Client Consent Form (Appendix J) in REMI in order to have their labs imported. Only the most recent lab results will be displayed in REMI. A history of all Iowa lab results can be found in the client's CAREWare profile.

FILE MAINTENANCE

Ryan White Part B providers are required to maintain an electronic file in the Ryan White Electronic Information (REMI) system for all clients who access Part B services through their agency. These files must be secure, with access limited to the case manager, the case manager's supervisor, and program staff who have a programmatic need to access the file. The Iowa RWPB Program may access clients' files at any time.

REQUIRED FORMS

The Iowa RWPB Program has developed a standardized set of forms that all Part B providers are required to use.* Below is a list of the required forms:

- Case Management Enrollment and Client Consent Form
- Client Rights, Responsibilities and Grievance Procedure
- Annual Assessment
- Acuity Scale
- Consent to Release of Confidential Information—as needed (Appendix L)
- Consent to Exchange of Confidential Information—as needed (Appendix M)
- Discharge Form (if applicable)
- Exception to Policy (if applicable).

For clients obtaining financial assistance, other forms or applications are required, such as:

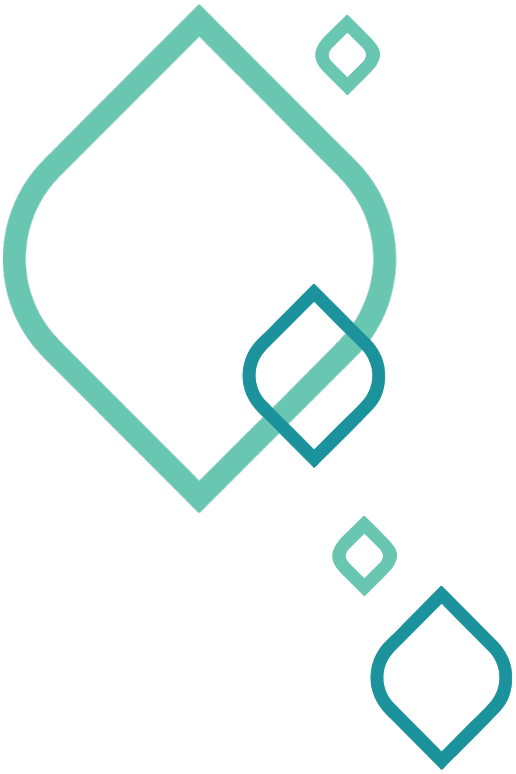
- Emergency Financial Assistance Application
- Emergency Financial Assistance—Utilities Application
- Health Insurance Premium and Cost-Sharing Assistance Application
- Housing Assistance Application
- Housing Assistance and Emergency Financial Assistance—Utilities Application
- Medical Services Financial Assistance Application (Iowa RWPB Program Pays)
- Naloxone Assistance Application
- Preauthorization for Medical Services Financial Assistance Application (Iowa RWPB Program pays)
- Tobacco Cessation Application
- Delta Dental Application (paper application).

*Additional forms are required for BDAP. See the BDAP manual for more details.

ARCHIVED PAPER FILES

Archived paper files require the same amount of security as electronic client files in REMI. Archived client files must be kept in a confidential, secure, and locked space with access limited only to the case manager, the case manager's supervisor, and any other program staff with a programmatic need to access the file. The Iowa RWPB Program may request access to the archived paper files. The archived client files must be kept for a minimum of seven (7) years.

ADMINISTRATION



NATIONAL MONITORING STANDARDS

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

1. Universal Monitoring Standards that cover fiscal and program requirements that apply to Ryan White Part A and Part B programs.
2. Fiscal Monitoring Standards have two separate versions—one for Ryan White Part A and one for Ryan White Part B.
3. Program Monitoring Standards have two separate versions—one for Ryan White Part A and one for Ryan White Part B. They also include some specific BDAP components.

The Iowa RWPB Program at the Department of Health and Human Services ensures that all Part B sub-recipients in Iowa meet the expectations outlined in the monitoring standards. It is also the responsibility of each subrecipient to read and understand the standards. To review the complete National Monitoring Standards, visit the HRSA website.

QUALITY MANAGEMENT PROGRAM

The Ryan White HIV/AIDS Program legislation requires Ryan White recipients to develop and implement a clinical quality management program. According to HRSA/HAB Policy Clarification Notice (PCN) 15-02, a quality management (QM) program, "is the coordination of activities aimed at improving patient care, health outcomes, and patient satisfaction."

The Iowa RW Part B QM Program has three components: Infrastructure, Performance Management, and Quality Improvement (QI). RW Part B subrecipients are also required to develop their own QM program using these three components. The RW Quality Coordinator will provide technical assistance to subrecipients as needed. The following outlines the QM program expectations of RW Part B subrecipients.

INFRASTRUCTURE

Infrastructure is defined as the fundamental components needed to develop and sustain a QM program. RW Part B subrecipients are required to:

- **Have dedicated QM staff.** The FTEs dedicated to QM will vary by subrecipient agency. Smaller agencies may have a portion of their leadership's FTEs responsible for QM activities, while larger agencies may have 1 FTE completely dedicated to QM. The Iowa RWPB Program will work with each subrecipient agency to determine the appropriate amount of staff time dedicated to QM.
- **Complete the Subrecipient QM Organizational Assessment (OA) annually.** Results will be reviewed by the Iowa RWPB Program. The Department together with the subrecipient will create a workplan for the contract year based on the OA results.
- **Develop a QM Plan.** The Iowa RWPB Program will provide a template that includes all of the required components. If a subrecipient wishes to use an alternative format, they must submit it to the Iowa RWPB Program for approval.

- **Participate in QM activities organized by the Iowa RWPB Program.** This may include activities such as trainings, webinars, quality improvement projects, etc.

PERFORMANCE MEASUREMENT

Performance measurement as defined by PCN 15-02 is "the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction." Part B subrecipients are required to:

- **Upload signed Case Management Enrollment & Client Consent forms into REMI.** This provides the HIV Surveillance authorization to import viral load and CD4 cell count test results into CAREWare, and subsequently REMI. These results are used to calculate a variety of performance measures including retention in care and viral suppression.
- **Submit Quarterly Reports.** These reports provide the Department with service utilization and other important datasets.
- **Review Data Feedback Reports.** These are provided to subrecipients quarterly and contain retention in care and viral suppression results. Subrecipients should use these reports to examine health disparities among their clients and inform service delivery.
- **Assist with Consumer Needs Assessment (CNA) surveys.** These are completed every three years and are distributed by subrecipient agencies. The most recent CNA was completed in 2019.
- **Conduct annual client satisfaction surveys.** The Department is working to standardize these surveys and will contact subrecipients with more information in the near future.

QUALITY IMPROVEMENT

Quality improvement is "the development and implementation of activities to make changes to the program in response to the performance data results," as defined by PCN 15-02. Part B subrecipients are required to:

- **Identify opportunities for improvement.** Identified opportunities for improvement should be included on the QM OA and in quarterly reports.
- **Conduct at least one QI activity annually in collaboration with the Ryan White Quality Coordinator.** The Ryan White Quality Coordinators role may vary from consultant to facilitator.
- **Participate in QI activity follow-up discussions with the Ryan White Quality Coordinator.** These are typically scheduled at 30 days, 90 days, 6 months, and 1 year post-QI events.

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FISCAL POLICIES

PAYER OF LAST RESORT

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

UNALLOWABLE COSTS

Ryan White funds may not be used to make cash payments to clients of Ryan White funded services. This prohibition includes cash incentives and cash payment for Ryan White core medical and support services. Where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Agencies are advised to administer voucher and store gift card programs in a manner that assures that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards.

Other unallowable costs include:

- Emergency Room Visits
- Inpatient Services
- Outpatient Surgery under General Anesthesia
- Clothing
- Pet food and supplies
- Furniture and appliances
- Maintenance of personal vehicles
- Funeral and Burial Expenses
- Property taxes, local and state taxes
- Clinical trials
- Massage
- Gym memberships / Recreational Activities
- Mortgages / Deposits
- Pre-Exposure Prophylaxis (PrEP)
- Non-occupational Post-Exposure Prophylaxis (nPEP)
- Materials promoting IV drug use or sexual activity
- International travel

EXPENDITURE MONITORING

All Core Medical and Support Services require careful monitoring of expenditures to ensure funding will be available throughout the program year. Part B providers are responsible for:

- Developing and maintaining policies and procedures for monitoring expenditures
- Effectively utilizing and allocating expenditures
- Accurately tracking the amount of assistance provided for each service to ensure the total combined amount per client does not exceed the award amount per contract year
- Providing a mechanism through which payment can be made on behalf of the client
- Maintaining and producing, upon request, documentation verifying payments were made to appropriate vendors.

FINANCIAL MANAGEMENT

Subrecipient agencies are required to have policies and procedures in place to ensure compliance with HRSA financial management standards as outlined in the Fiscal Monitoring Standards for RWHAP Part B Recipients: https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/2022-rwhap-nms-part-b.pdf.

Subrecipient agencies shall adhere to the 10% limit on the proportion of federal funds spent on administrative activities during the grant year and shall ensure that administrative funds are only used for allowable expenditures. Administrative activities include routine grants administration and monitoring. Allowable, allocable, and reasonable expenditures include those that are usual and recognized overhead activities, management and oversight of specific programs funded by Ryan White Part B, and other types of program support such as quality assurance activities.

Subrecipient agencies shall ensure grant funds are only spent on allowable expenses in accordance with federal guidelines. The Request for Proposal and subrecipient contract will include information on unallowable expenses. Ongoing technical assistance will be provided on the allowability of expenses and agencies should seek guidance from the Iowa RWPB Program if questions arise on allowability. Agencies shall have policies and procedures in place to ensure appropriate use of Ryan White Part B funds.

Subrecipient agencies shall ensure that Ryan White Part B funds are utilized as a payer of last resort.

Subrecipients shall report annually on capital assets purchased with Ryan White Part B funding that have a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

Subrecipient agencies shall ensure all expenditures allocated to the Ryan White Part B grant are reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs. Agencies shall have policies and procedures in place to ensure expenditures are reasonable.

Subrecipient agencies shall ensure compliance with the Single Audit Act of 1996 by completing A-133 audits if expending more than $500,000 per year in federal grants.

Required Documentation

- Detailed budgets submitted each year via the Request for Proposal or Request for Application
- Monthly claims submitted within 45 days of the month the claim was expensed
- Supporting documentation submitted with claims at the request of the Iowa RWPB Program.

SUBRECIPIENT EMPLOYEE TRAVEL

Subrecipient employees shall be reimbursed for actual and necessary travel expenses incurred in the performance of official job duties, subject to applicable limitations.

In-State Reimbursement Rates

The Iowa RWPB Program will not reimburse travel amounts in excess of limits established by the Iowa Department of Administrative Services, State Accounting Enterprise. Current in-state maximum allowable amounts are:

- Food- $12.00/breakfast, $15.00/lunch, $29.00/dinner
    - In accordance with the Iowa Department of Administrative Services Procedure, meals will not be reimbursed if an overnight stay is not required.
- Lodging—Maximum $120.00 plus taxes per night
- Mileage—Maximum of $0.50 per mile.

Meals

Allowable meals include food and drink consumed in one sitting. This may include appetizers, entrees, desserts, and non-alcoholic beverages. Tips are allowable at appropriate locations for no more than 15% of the allowable meal expense, before taxes. Meal reimbursement is only allowable in conjunction with an overnight stay.

Items not eligible for reimbursement include alcoholic beverages and break or refreshment items purchased to be consumed throughout the day such as multiple beverages, candy bars, and bags of chips. Non-food items such as gum, breath mints, antacids, and aspirin are not reimbursable. Tips are not allowable at fast food restaurants, self-service locations, gas stations, grocery stores, and convenience stores.

Receipts are required for all meal expenses. Receipts must include date, time, city, state, and itemization of what was consumed and its cost.

Lodging

Lodging will be reimbursed at a rate of up to $120.00 per night, plus applicable taxes. Staff shall request the government rate when making lodging reservations. Itemized receipts with method of payment provided are required for reimbursement. To be reimbursed for lodging that occurred at a lodging provider that must pay Iowa hotel/motel taxes, prior to the lodging event, the Contractor shall confirm that the lodging provider has received the Human Trafficking Prevention Training Certification at the website maintained by the Iowa Department of Public Safety, currently at https://stophtiowa.org/certified-locations, as required by Iowa Code § 80.45A(5). The Contractor shall submit to the Agency a screenshot of this verification showing the lodging provider is a certified location with the claim for reimbursement. This applies to all in-state lodging, conferences, meetings, or any other state funded event. Use of lodging providers who are not certified will not be reimbursed. Certification of a lodging provider will be verified by the Agency before reimbursing this expenditure in a claim.

Mileage

Mileage is reimbursed at $0.50 per mile. Gas receipts are not reimbursable. The most direct route must always be used. Staff members who are traveling together are expected to carpool whenever possible.

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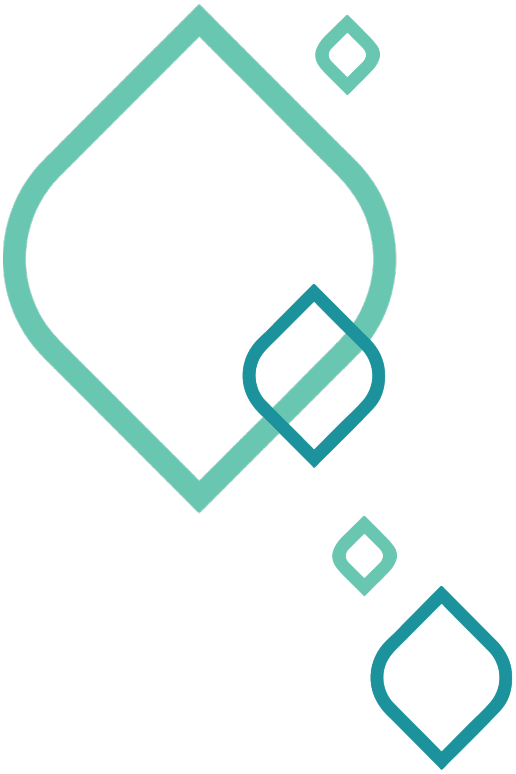
REPORTING REQUIREMENTS

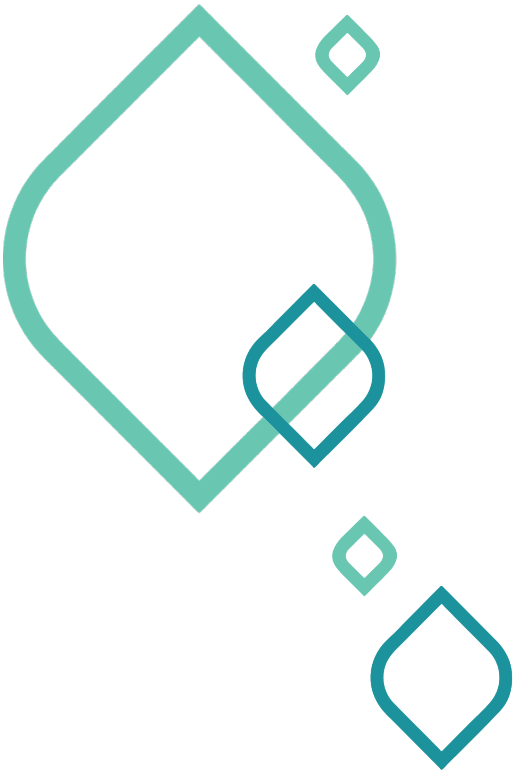
The Ryan White Part B program requires routine reporting. All required reports shall be submitted by the due date and via the proper reporting mechanism (IowaGrants, email, HRSA website). The required reporting is noted in the HIV Client Services Program contract and is illustrated in the table below:

Report Title	Frequency	Reporting Mechanism	Due Date
EIS Quality Assurance Reports (only if funded for EIS services)	Monthly	Submit via Aphirm	The 15th day of the following month
FFATA Report	Annually	Submit via IowaGrants	Within 15-30 days of the start date of the contract
Narrative Progress and Statistical Reports	Quarterly	Submit via email to Client Services Coordinator	First Friday of the second month following the quarter's end (e.g. if the quarter ends June 30, the report is due the first Friday in August)
Ryan White HIV/AIDS Program Services Report (RSR)	Annually	Submit via the HRSA website	Typically in March (due date determined by HRSA)

APPENDICES



APPENDIX A:
Iowa Ryan White Part B Provider List



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RYAN WHITE PART B PROVIDER LIST

Cedar AIDS Support System
900 Tower Park Drive
Waterloo, Iowa 50701
P: 319-272-2437

Dubuque Visiting Nurse Association
660 Iowa Street
Dubuque, Iowa 52001
P: 563-556-6200

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

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

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

River Hills Community Health Center
201 S. Market Street
Ottumwa, Iowa, 52501
P: 641-455-5773

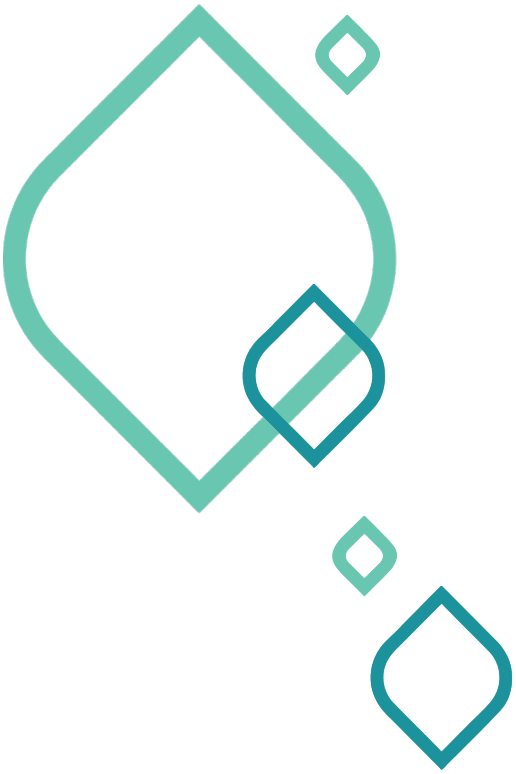
Siouxland Community Health Center
1021 Nebraska Street
Sioux City, Iowa 51102
P: 712-226-8973

The Project at Primary Health Care
1200 University Ave, Suite 120
Des Moines, Iowa 50314
P: 515-248-1595

The Project Quad Cities
1701 River Drive, Suite 100
Moline, IL 61265
P: 563-231-4520

University of Iowa Health Care
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-335-7444

APPENDIX B:
Iowa Ryan White Part C Provider List



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RYAN WHITE PART C PROVIDER LIST

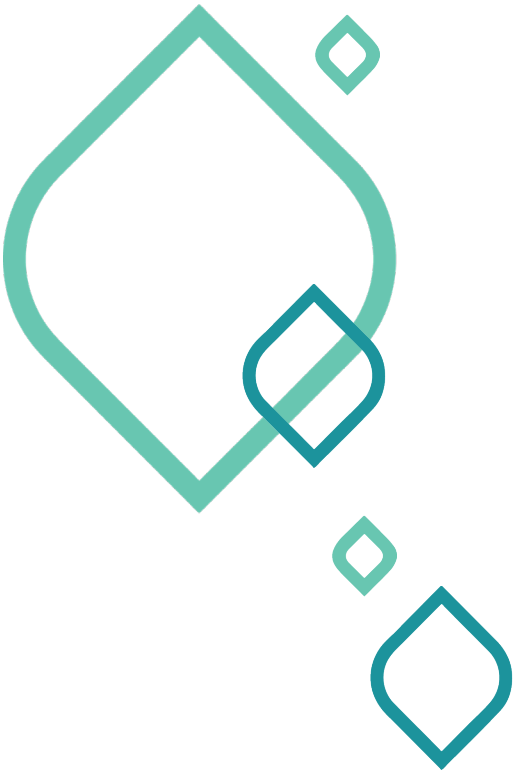
Genesis Health Group Infectious Disease
1351 W Central Park
Suite 360
Davenport, Iowa 52804
P: 563-421-4244

Siouxland Community Health Center
1021 Nebraska Street
Sioux City, Iowa 51102
P: 712-224-1828

The Project at Primary Health Care
1200 University Ave, Suite 120
Des Moines, Iowa 50314
P. 515-248-1595

University of Iowa Health Care
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-335-7444

APPENDIX C:
Housing Opportunities for Persons with AIDS (HOPWA) Provider Map & List



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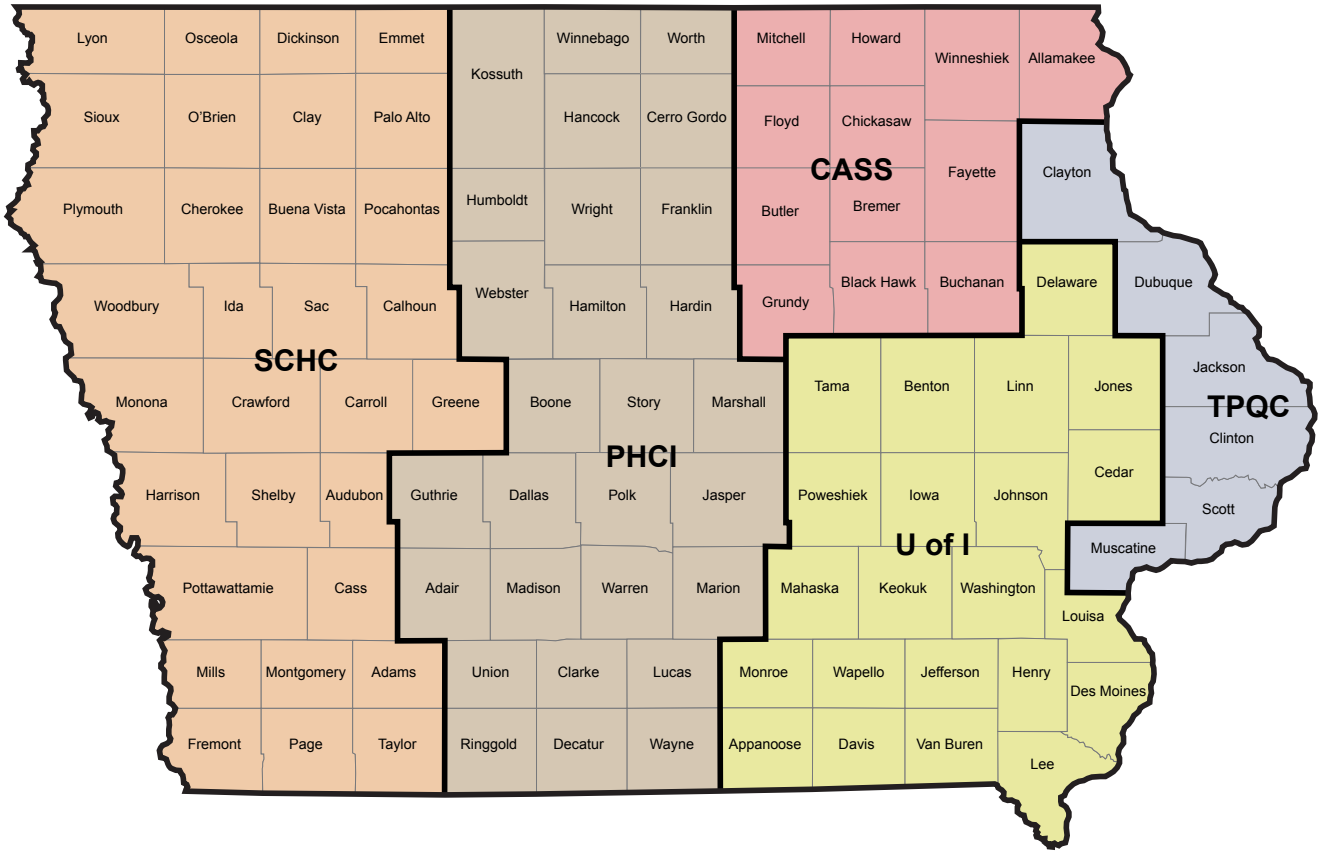
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) PROVIDER MAP & LIST



Siouxland Community Health Center (SCHC)
1021 Nebraska Street
Sioux City, Iowa 51102
P: 712-224-1828

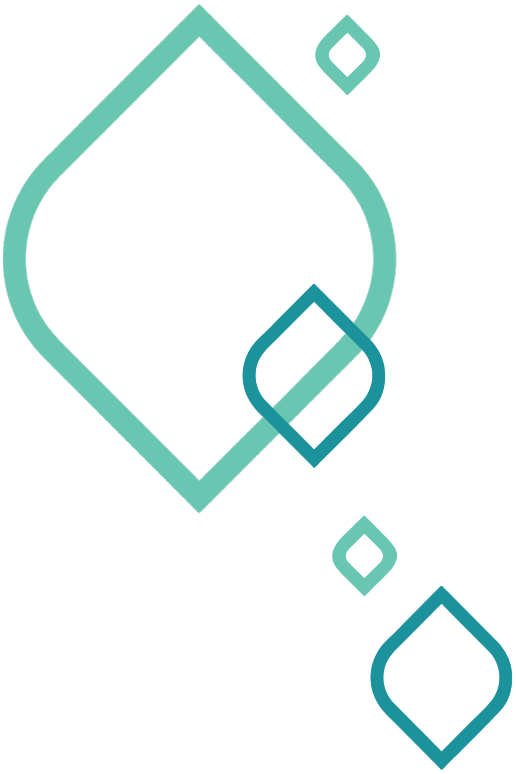
Cedar AIDS Support System (CASS)
900 Tower Park Drive
Waterloo, Iowa 50701
P: 319-272-2437

The Project of the Quad Cities (TPQC)
1701 River Drive, Suite 100
Moline, IL 61265
P: 563-231-4520

Primary Health Care, Inc. (PHCI)
1200 University Ave, Suite 120
Des Moines, Iowa 50314
P. 515-248-1595

University of Iowa Health (U of I)
200 Hawkins Drive SW34-GH
Iowa City, Iowa 52242
P: 319-335-7444

APPENDIX D:
Core Medical Services Definitions



IOWA HHS

RYAN WHITE CORE MEDICAL SERVICES DEFINITIONS

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

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

Health Insurance Premium & Cost-Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

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

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

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

Medical Case Management Services are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members, needs and personal support systems. Medical case management includes the provision of treatment adherence, counseling to ensure readiness for, and adherence to, complex HIV treatments. Key activities include (1) initial assessment of service needs (2) development of a comprehensive, individualized service plan (3) coordination of services required to implement the plan (4) client monitoring to assess the efficacy of the plan and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face to face, phone contacts, and any other forms of communication.

Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

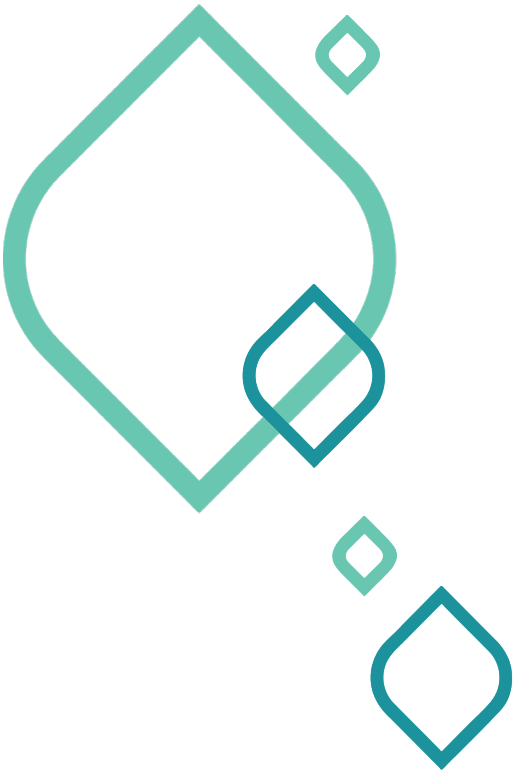
Mental Health Services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services.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

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

Outpatient/Ambulatory Health Services is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. An emergency room is not an outpatient setting, and emergency room services are unallowable through Ryan White Part B funding. Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and screening of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

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

APPENDIX E:
Support Services Definitions



IOWA HHS

RYAN WHITE SUPPORT SERVICES DEFINITIONS

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

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

Child Care Services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program related meetings, groups, or trainings.

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

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

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

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

Legal Services see Other Professional Services

Linguistic Services include the provision of interpretation and translation services.

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

Other Professional Services include the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: legal services, permanency planning, income tax preparation, assistance with public benefits such as Social Security Disability, preparation of living wills and power of attorney.

Outreach Services are programs that have as their principal purpose identification of people with undiagnosed HIV disease or identification of those who know their status but are not in care (i.e. case finding). They do not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in

coordination with local HIV prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is high probability that individuals with HIV infection will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

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

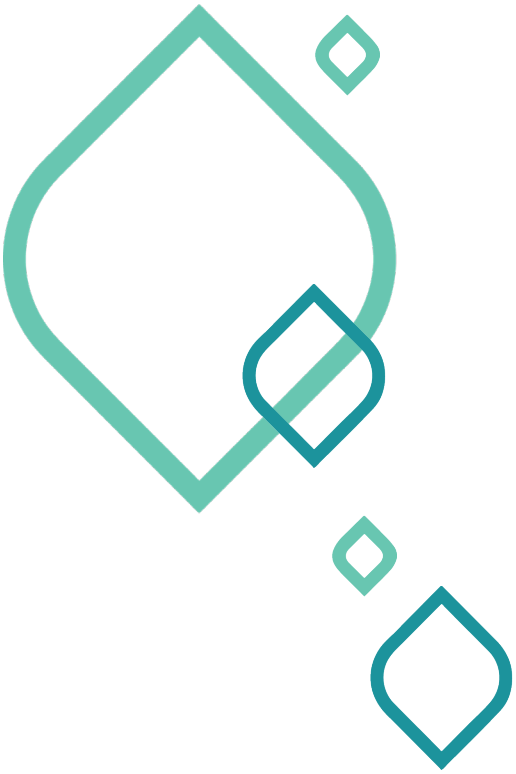
Referral for Health Care & Supportive Services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made with the non-medical case management system by a professional case manager, informally through support staff, or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

Rehabilitation Services is the provision of HIV-related therapies intended to improve or maintain a client's quality of life and optimal capacity for self-care on an outpatient basis, and in accordance with an individualized plan of HIV care.

Respite Care Services is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for clients in order to temporarily relieve their primary caregiver responsible for their day-to-day care.

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

APPENDIX F:
Delta Dental Insurance Application



IOWA HHS

Iowa Department of Public Health

Individual Enrollment/Change Application

New Applicant Change of Coverage Name/Address Change

Delta Dental of Iowa Email: individualproduct@deltadentalia.com PO Box 9010 Fax: 1-888-264-1433
Johnston, IA 50131 – 9010 Customer Service: 1-877-423-3582 x3

Section I Policyholder Information

Name (First, Middle Initial, Last)	**Telephone No:** ( )	**Status:** Single Other IDPH Group Plan; 42758
Mailing Address – Street City State Zip		
E-mail address		**Requested Effective Date: ____ /01/____**
Product Choice: Preventive Preferred		

Section II Person to be Covered

First Name Middle Initial Last (if different)	Social Security Number	Birthdate	Sex	Other Dental Coverage
Self		___/___/___		• No • Yes

Other Dental Coverage—If you have had dental insurance through another carrier where the employer pays any portion of the cost or makes payroll deductions, please complete: **Policyholde**r:

_____

_____

____/____/___ Single Family **Name of other dental carrier Policy Number Effective Date Contract type**

Prior Dental Coverage—Have you had prior dental coverage within the past 60 days? Yes No

Note: Your previous coverage will be verified. Credit towards waiting periods may be given for those individuals that were covered under a qualifying plan within the past 60 days. You will need to provide the following: verification of coverage on previous carrier's letterhead, coverage effective date and termination date, who was covered and a summary of benefits covered under your policy.

IOWA HHS

Section III Agreement and Certification

I have read and understand the Agreement and Certification of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ ____/____/____ Applicant Signature Date

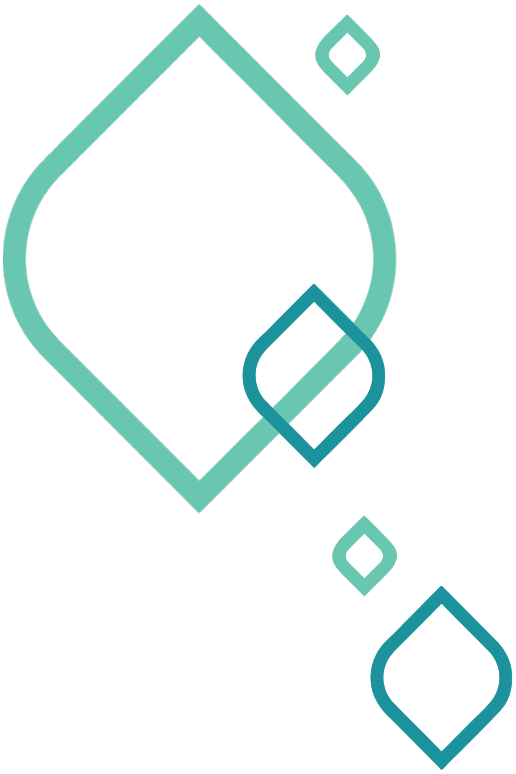
Agreement and Certification

I certify I am legally authorized to apply for coverage for myself. I am a resident of the state of Iowa. I understand I am applying for an application for individual dental coverage offered by Delta Dental of Iowa. I understand the Iowa Department of Public Health is responsible to pay monthly premium charges to Delta Dental of Iowa for this coverage, and if payment is not made when due, my coverage is subject to termination. I further understand I am not eligible to apply for individual dental coverage offered by Delta Dental of Iowa for a period of 24 months from the date of termination of a prior individual policy, either voluntarily or involuntarily, unless I had other continuous coverage with similar qualifying benefits. I understand if coverage under this application is terminated in the future, either voluntarily or involuntarily, I will not be eligible to apply for Delta Dental of Iowa individual coverage for a period of 24 months from the date of termination of my current Delta Dental of Iowa individual coverage, unless I have other continuous coverage with similar qualifying benefits. I understand that coverage for the dental policy applied for will not start until after this application and the required monies for the first month's premium are received and accepted by Delta Dental of Iowa and an effective date is established by Delta Dental of Iowa. Applications must be received by the 20th of the month to be effective the first of the following month. Applications received after the 20th will be effective the first of the next month.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental of Iowa will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental of Iowa will be entitled to declare the dental policy applied for void and refuse allowance of benefits to any person hereunder.

I authorize any health care provider to release medical records to Delta Dental of Iowa when reasonably related to the dental coverage for which I have applied. If any law or regulation requires additional authorization for release of dental records, I will give this authorization.

APPENDIX G: Department of Public Health Change Request Form



IOWA HHS

DELTA DENTAL

Department of Public Health Change Request Form

Please complete this form and send to:
Email: individualproduct@deltadentalia.com
Fax: 1-888-264-1433
Customer Service: 1-877-423-3582, x3

Member Information:

Name _____

Address _____

City/ST/Zip _____

Member ID _____

☐ Termination of Coverage – No longer eligible for Payment from Department of Health and want to term coverage effective _____.

☐ Continue Coverage – No longer Eligible for Payment from Department of Health, start to bill member **(Complete the following ACH information)** effective _____.

{Intentional Blank Space}

DELTA DENTAL OF IOWA
ACCOUNT WITHDRAWAL AUTHORIZATION

Name of Financial Institution

Address of Financial Institution City State Zip Code

Account Type: ☐ Checking ☐ Savings

IOWA HHS

Bank Routing Number _____ Account Number _____

I certify to the best of my knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).

I hereby authorize Delta Dental of Iowa and the financial institution named to withdraw monthly premium payments from my checking or savings account that I selected. I further authorize Delta Dental of Iowa to initiate adjustment entries to this account when necessary.

I understand my first month's premium will be withdrawn from my account starting on the 5th calendar day of the month of the policy effective date, and thereafter will be deducted on the 5th calendar day of each month. This authorization is for the purpose of paying monthly premiums for Delta Dental of Iowa Individual and Family Dental Insurance. I also understand the amounts are subject to change at lease annually and Delta Dental will send me written notification of such changes at least 60 days before the rate change takes effect.

This authority for payments is to remain in full force and effect until Delta Dental of Iowa has received written notification from me of its withdrawal.

I understand in order to revoke my authorization provided or make changes to my payment information I must contact Delta Dental of Iowa at IndividualProduct@deltadentalia.com or send a written request to Delta Dental of Iowa P.O. Box 9010, Johnston, Iowa 50131-9010. Please keep in mind that you must provide Delta Dental 20 days notice prior to the requested termination date. Termination dates are always the last day of the month.

Delta Dental of Iowa SHALL BEAR NO LIABILITY OR RESPONSIBILITY FOR ANY LOSSES OF ANY KIND THAT YOU MAY INCUR AS A RESULT OF AN ERRONEOUS STATEMENT ANY DELAY IN THE ACTUAL DATE ON WHICH YOUR ACCOUNT IS DEBITED, OR OUR FAILURE TO PROVIDE ACCURATE AND/OR VALID PAYMENT INFORMATION.

_____ _____
Printed Name of Insured Delta Dental ID Number

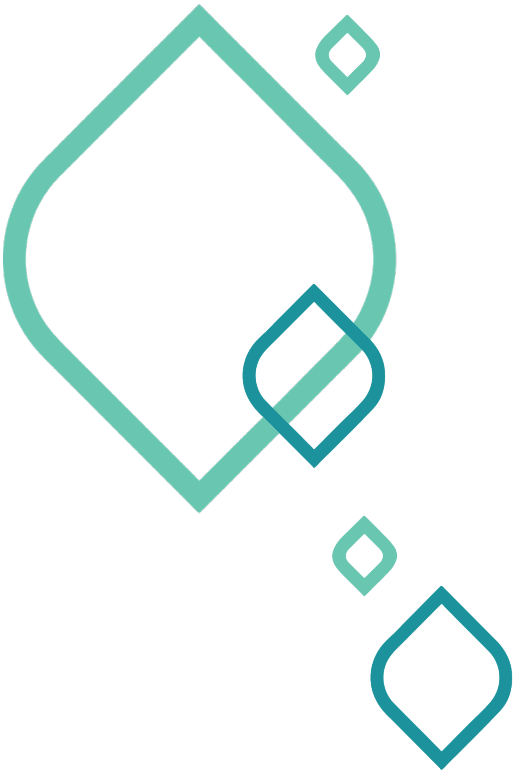
_____ _____
Name and Signature of Account Holder Date Signed

TERMINATION OF COVERAGE

I understand by terminating coverage, either voluntarily or involuntarily, I will not be eligible to apply for Delta Dental of Iowa individual coverage for a period of 24 months from the date of termination of my current Delta Dental of Iowa individual coverage, unless I have other continuous coverage with similar qualifying benefits. Termination must be received by the 20th of the month to be effective the end of the current month, otherwise coverage will be terminated at the end of the following month.

_____ ____/____/____
Subscriber Signature Date

APPENDIX H:
Naloxone Eligibility Assessment



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Eligibility Assessment to receive naloxone for reversal of opioid-related overdose

ASSESSMENT CRITERIA	YES	NO
Individual is: 1) a person at risk, 2) a family member or friend of person at risk, 3) a person in a position to assist a person at risk, 4) a first responder		
Person at risk does NOT have a known allergy or sensitivity to naloxone or any component of the product to be dispensed (Answer "yes" if there is no known allergy or the person at risk is not known to the individual)		
Individual is oriented to person, place and time and understands the essential components of opioid-related overdose, appropriate response, and naloxone administration.		
Individual is determined to be ELIGIBLE to receive naloxone at this time (complete absence of "no" responses to above criteria)**		

**Even if individual is NOT eligible to receive naloxone at this time, this assessment form must be maintained with pharmacy records for at least two years, be available for inspection and copying by the board or its authorized agent, and must be submitted to the Iowa Department of Public Health.

PREVIOUS PRESCRIPTION INFORMATION	
If recipient has received naloxone previously, the last dispensed product was:	CHECK
1. Administered to reverse an opioid-related overdose	
2. Lost	
3. Stolen or confiscated	
4. Destroyed or expired	

By my initials below, I acknowledge:

1. I have been provided with information and understand the essential components of opioid-related overdose, appropriate response, naloxone storage conditions, and naloxone administration.
2. I attest that I will provide opioid-related overdose, appropriate response, and naloxone storage and administration information to any other person in a position to assist who may use the medication.
3. I understand that no further distribution of this product is allowed.

_____ _____
(Eligible recipient initials) Date

If eligible recipient is purchasing on behalf of an agency or harm reduction organization, the name of the agency or harm reduction organization: _____

Below to be completed by the authorized pharmacist:

By my signature below, I attest that I have, in good faith, provided the required training and education to the eligible recipient identified above:

_____ Date: _____ IA **PHARMACY** License No./County: _____/_____
(Authorized RPh/Intern signature) **(NOT Pharmacist license)**

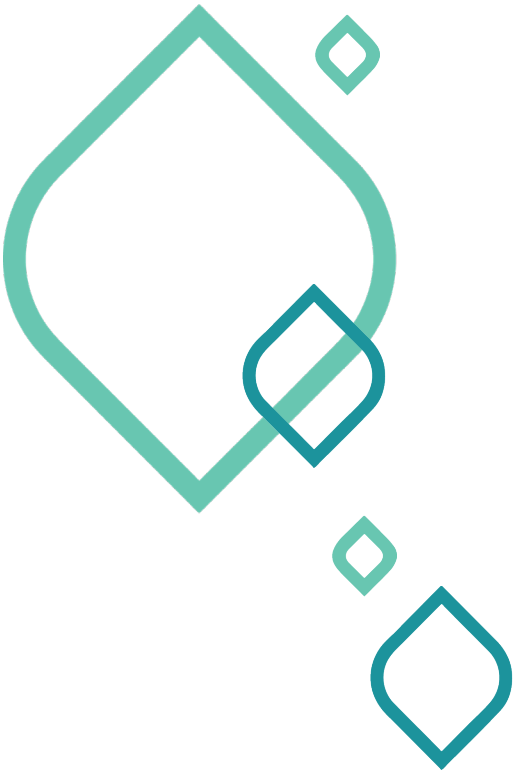
Product dispensed: _____ Qty of kits dispensed: _____

Medical director under whose authority granted this prescription: _____

Individual is eligible, but did not receive naloxone (provide reason) _____

Submit this assessment form to Iowa Department of Public Health via fax to 515-725-4098 within seven (7) days of dispensing or denied eligibility.

APPENDIX I:
Naloxone Application



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RYAN WHITE NALOXONE APPLICATION

Naloxone, an opioid antagonist and overdose prevention agent, is now available at Iowa pharmacies. Naloxone is on the Iowa BDAP formulary and available to Ryan White clients through the Ryan White Opioid-Related Overdose Prevention Program. Clients do not have to be enrolled in BDAP to receive Naloxone. However, clients must be at risk of an opioid-related overdose, a family member or friend of a person at risk, or in a position to assist a person at risk.

Date: _____ Client Name: _____

Client Date of Birth: _____ Gender: _____

Support Person (if requesting on behalf of a client): _____

Client/Support Person Mailing Address (where medication will be sent): Street: _____ City: Zip: _____ _____
Client/Support Person Phone Number:

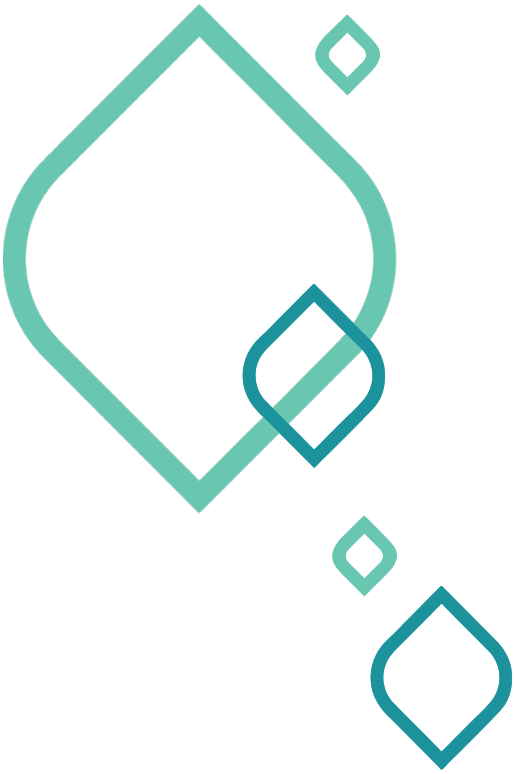
Is client enrolled in Ryan White Part B Case Management? ☐ Yes ☐ No/Part C Only
Case Manager/Nurse:

Client's Monthly Income: $_____ ☐ verification attached ☐ verification in client Part B/C file ☐ Applicant enrolled in Medicaid (<138% FPL—verification not required)
Household Size: _____ **FPL**_____**%**

Client Insurance Coverage (if applicable): ☐ Medicaid ☐ Medicare ☐ Commercial insurance ☐ No insurance	
Insurance Company:	**RX Group:**
Member Name:	**RX Bin:**
Member ID:	**PCN:**
Insurance Company Phone #:	

Service entered in CAREWare under "Naloxone/RWB"? ☐ Yes
Demographics up to date in CAREWare? ☐ Yes

APPENDIX J: Case Management Enrollment & Client Consent Form



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CASE MANAGEMENT ENROLLMENT AND CLIENT CONSENT FORM

(Name of agency)

Introduction

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

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

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

Data Privacy/Confidentiality

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

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

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

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

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

Duration of Services

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

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

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

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

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

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

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

Laboratory data may be released as far back as January 1, 2010, if available. Please indicate the earliest date for which laboratory data should be made available to your case manager by checking **ONE** box:

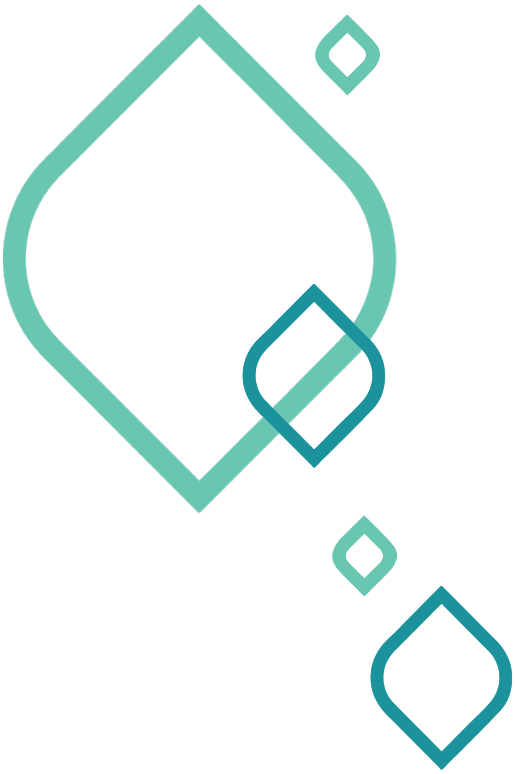
☐ Earliest Available ☐ First of month for the date signed below ☐ Other date (specify) _____

Client Name (Please print) **Client Signature** **Date**

Client Date of Birth **Client Gender**

Case Manager Name (Please Print) **Case Manager Signature** **Date**

APPENDIX K: Clients Rights, Responsibilities, and Grievance Form



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CLIENT RIGHTS, RESPONSIBILITIES AND GRIEVANCE PROCEDURE

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

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

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

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

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GRIEVANCE PROCEDURE:

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

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

   Iowa Department of Health and Human Services
   Division of Public Health
   Ryan White Program, Client Services Coordinator
   321 East 12th Street
   Des Moines, IA 50319

Name _____

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

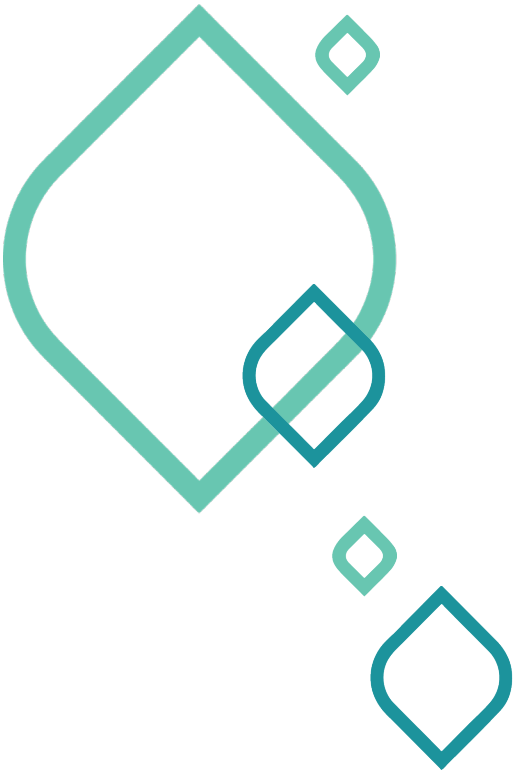
_____ _____

Client's Signature Date

_____ _____

Staff Signature Date

APPENDIX L:
Consent to Release Confidential Information



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CONSENT TO RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

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

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

TO: _____

_____

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

_____ HIV Disease information and/or records

_____ Mental Health information and/or records

_____ Substance Use information and/or records

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

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

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

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

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

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

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

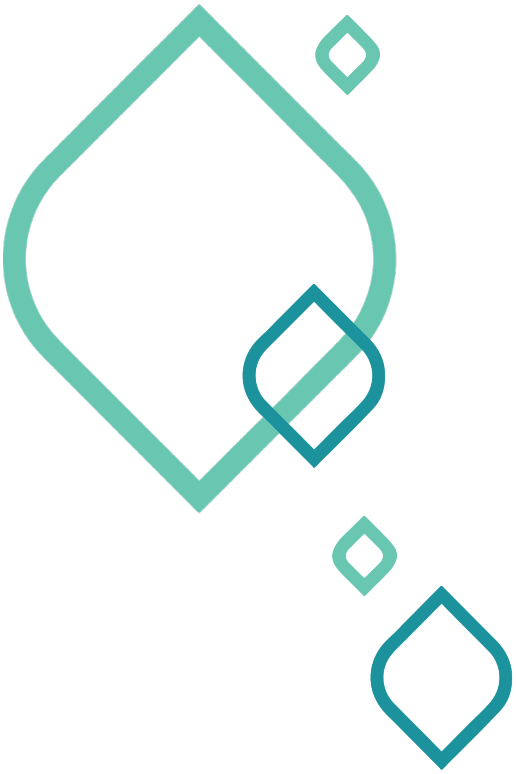
A photocopy of this signed Authorization will have the same validity as the original.

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

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

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

APPENDIX M:
Consent to Exchange of Confidential Information



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CONSENT TO EXCHANGE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

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

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

WITH: _____

_____

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

_____ HIV Disease information and/or records

_____ Mental Health information and/or records

_____ Substance Use information and/or records

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

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

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

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

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

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

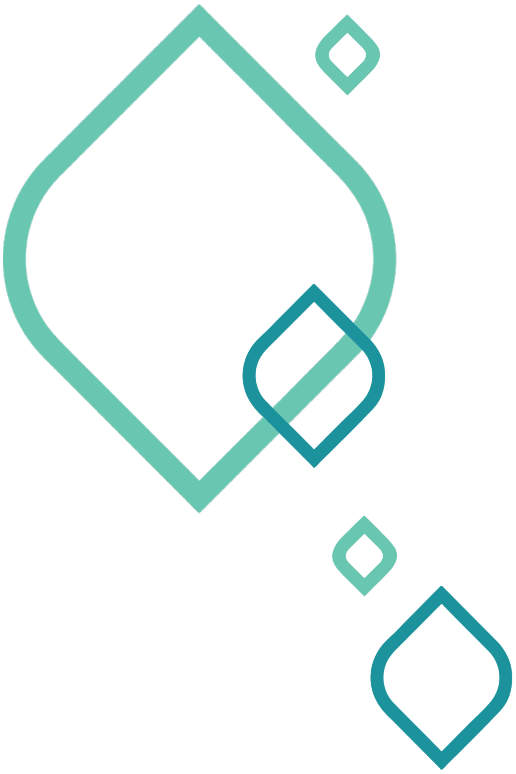
A photocopy of this signed Authorization will have the same validity as the original.

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

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

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

APPENDIX N:
Diligent Search Checklist



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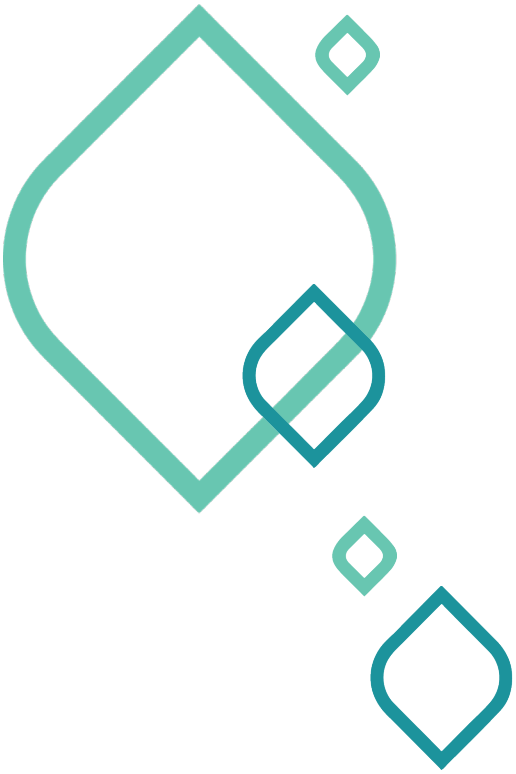
DILIGENT SEARCH CHECKLIST

This checklist can be used when attempting to reach clients who are not responding to typical contact attempts, and can serve as a tool to help determine when resources have been exhausted. There is no particular order for these steps, and you may need to complete some of them multiple times based on information gathered. This checklist is optional, and does not need to be submitted to the Iowa Department of Health and Human Services.

Checklist Start Date: _____ Client Name: _____

- ☐ **Consultation with supervisor**—Optional, follow agency procedures.
- ☐ **Phone Calls**—Phone call attempts should be made on different days throughout a week, including weekends if necessary, and at different times of the day (i.e. daytime and evening).
- ☐ **Text Messages**—Numerous text messages should be sent whenever permission has been given by the client. Ensure communication is limited to general information in an effort to avoid disclosing confidential data.
- ☐ **Emails**—Numerous emails should be sent whenever permission has been given by the client. Ensure communication is limited to general information in an effort to avoid disclosing confidential data.
- ☐ **Letters**—Letters should be mailed at a minimum once a month as long as a current address is available, and client has given permission for agency to send mail.
- ☐ **Emergency Contacts**—Emergency contacts should be utilized for obtaining client contact information, whenever ROIs are current.
- ☐ **Other ROIs (landlords, social workers, etc.)**—Other appropriate individuals should be utilized for obtaining client contact information, whenever ROIs are current.
- ☐ **Medical Staff** (NCM, ID Provider, etc.)**—**Medical staff should be utilized for obtaining most recent client contact and lab information. Ensure current ROI is on file if required.
- ☐ **Pharmacy**—Pharmacy should be utilized for obtaining most recent client contact and fill history information. Ensure current ROI is on file if required.
- ☐ **Social Media/Google Search**—Do not use personal social media to make contact with client. Only utilize social media if your agency allows this.
- ☐ **Incarceration Search**—Check IA Dept. of Corrections, VINE and county inmate lists.
- ☐ **Home/Community Visits**—Home visits should be utilized when appropriate, taking into consideration the client and your agency's policies.
- ☐ **Request Data to Services Investigation**—Email Data to Services Coordinator

APPENDIX O:
Potential False-Posititive Test Results Policies and Procedures



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POTENTIAL FALSE-POSITIVE TEST RESULTS POLICIES AND PROCEDURES

PURPOSE

The purpose of this policy is to outline the expectations that all Ryan White Part B service providers in Iowa are to follow when assisting individuals whose HIV status is in question due to a possible false-positive HIV test result.

DEFINITIONS

False-Positive Test Results—Tests that have been confirmed as positive via the CDC HIV testing algorithm (i.e., HIV Ag/Ab reactive and HIV-1Ab reactive) but that later are shown to be incorrect when the subject of the test has no virus detected on viral load and/or qualitative HIV nucleic acid test (NAT).

False Positives

- Screening and confirmatory tests came back positive but no viral load is detected (and the subject is not on medication and has not tested positive previously)
- Meet CDC's definition of positive for HIV

BACKGROUND

Iowa has seen an increasing rate of people with false positive test results over the last three years and a relatively high proportion in the context of 120-125 people with true positive tests per year.

Number of people with false positive test results documented by Iowa HHS:

- 2020 = 9
- 2021 = 12
- 2022 = 16

Unique needs exist for individuals who receive a false-positive HIV test result, including navigating complex systems, obtaining required follow-up lab work, and receiving assistance with transportation.

PROCEDURES

People who are confirmed as HIV positive based on CDC's definition but for whom a false positive is suspected should be enrolled in Ryan White Part B services. They should be provided the same services as other newly diagnosed individuals, including, but not limited to, case management, system navigation, and transportation. Case managers should follow the same enrollment processes used for other people living with HIV.

If Proof of Diagnosis is needed for services, it can be requested from the Iowa Surveillance Office by following the steps below.

Requesting Proof of Diagnosis from the Surveillance Office

1. Send a secure email to the Data to Services Coordinator (DTSC), Ariel Langtimm, with the following **required** information:
    a. Client Name and DOB

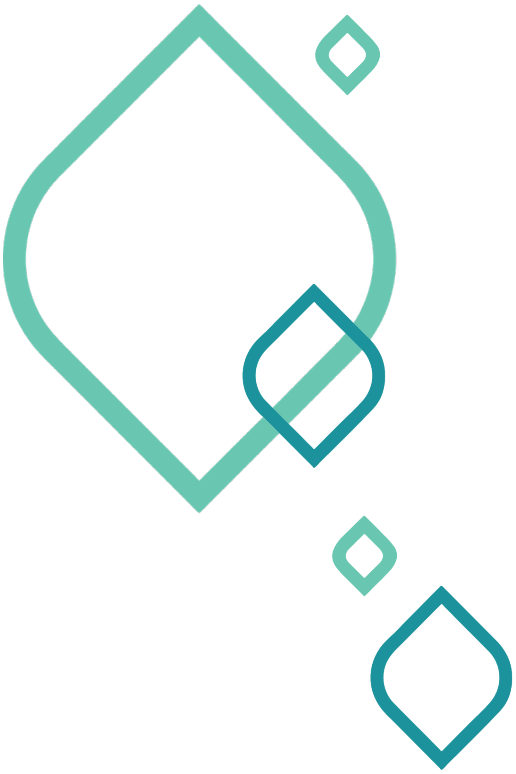
b. Client's Current Address
c. State the client was diagnosed in, if available/known

2. DTSC will process these requests and provide the completed form back to you.
3. DTSC will reach out to you if any additional information is needed or if a form cannot be completed.

If the client is determined to have a false positive test result (e.g., the client has no viral load detected, is not on medication, and has not previously tested positive),

- No additional financial assistance should be provided **with the exception of expenses related to determining their HIV status**. Ryan White Part B funds may be used to pay for all expenses related to determining the HIV status of a person with a false positive test result.
- REMI "To-do list":
  - Complete red sections of the application related to eligibility
  - Ensure proof of residency and proof of income is uploaded
  - Ensure original proof of diagnosis is uploaded
  - Complete all open/pending forms
  - Close out open goals
  - Document client's negative HIV status in case notes
  - Update client's HIV status to HIV Negative
  - Complete Discharge Form. For *Client Services Only Discharge Reasons*, select "Other". In the *Please Specify* text box document that client is not eligible for services due to HIV-negative status.
- CAREWare "To-do list"
  - Update eligibility status to "Not Eligible"
  - Discharge the client. Update enrollment status to "Referred or Discharge"

APPENDIX P:
Core Elements Table



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CORE ELEMENTS TABLE

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

CORE ELEMENTS	Medical Case Management (MCM)	Non-Medical Case Management (Non-MCM)	Brief Contact Management (BCM)	Maintenance Outreach Support Services (MOSS)
Approach	***Proactive***	***Proactive***	***Responsive***	***Responsive***
Initial Referral	Case Manager will attempt to contact the referred client within one to two business days. Case manager will follow up with referral source if unable to reach the client within five business days. **Best Practice:** Contact attempts occur within one business day.			
BDAP	All clients enrolled in BDAP must be enrolled in MCM, Non-MCM, or BCM.			N/A
Assessment	Annual Assessment required along with Acuity Scale **Best Practice:** Face to Face	Annual Assessment required along with Acuity Scale **Best Practice:** Face to Face	Annual Assessment required along with Acuity Scale **Best Practice:** Face to Face	MOSS Assessment required each year along with Acuity Scale May be face to face or via phone
Initial Enrollment Required Forms	The Case Management Enrollment & Client Consent Form and the Client Rights, Responsibilities, and Grievance Procedure form are required once upon initial enrollment.	The Case Management Enrollment & Client Consent Form and the Client Rights, Responsibilities, and Grievance Procedure form are required once upon initial enrollment.	N/A	N/A
Eligibility Determination	Eligibility documentation is reviewed annually and uploaded into REMI	Eligibility documentation is reviewed annually and uploaded into REMI	Eligibility documentation is reviewed annually and uploaded into REMI	Eligibility documentation is reviewed annually Self-attestation is acceptable proof.
Client Contact	Case manager will have client contact a **minimum** of 1 time per month.	Case manager will have client contact a **minimum** of 1 time every 3 months.	Case manager will have client contact a **minimum** of 1	Case manager will have client contact a

	Best Practice: Contact based on client's needs and on building and maintaining relationship.	**Best Practice:** Contact based on client's needs and on building and maintaining relationship.	time every 6 months. **Best Practice:** Contact based on client's needs and on building and maintaining relationship.	**minimum** of 1 time annually. **Best Practice:** Contact based on client's needs and maintaining relationship.
Referrals	Utilize the *Active Goals & Referrals* feature in REMI to ▪ Document referrals ▪ Document follow-up activities and outcomes	Utilize the *Active Goals & Referrals* feature in REMI to ▪ Document referrals ▪ Document follow-up activities and outcomes	Utilize the *Active Goals & Referrals* feature in REMI to ▪ Document referrals ▪ Document follow-up activities and outcomes	**Best Practice:** Move client to a higher level of case management when numerous referrals are being made.
Goals	**Required** Goals are updated when: ▪ Unanticipated changes take place in life ▪ When a change in the plan is identified ▪ When progress occurs ▪ Or at least every 6 months Utilize the Active Goals & Referrals feature in REMI to monitor progress and completion of all goals. **Best Practice:** Goals should be client-driven, actionable, attainable, and updated in real time.	**Required** Goals are updated when: ▪ Unanticipated changes take place in life ▪ When a change in the plan is identified ▪ When progress occurs ▪ Or at least every 6 months Utilize the Active Goals & Referrals feature in REMI to monitor progress and completion of all goals. **Best Practice:** Goals should be client-driven, actionable, attainable, and updated in real time.	**Not Required**	**Not Required**

Service Units	A service unit is documented in 15-minute increments, entered as "In MCM/RWB" or "Out MCM/RWB"	A service unit is documented in 15-minute increments, entered as "In Non-MCM/RWB" or "Out Non-MCM/RWB"	A service unit is documented in 15-minute increments, entered as "In BCM/RWB" or "Out BCM/RWB"	A service unit is documented in 15-minute increments, entered as "MOSS/RWB"
Consultation with Medical Provider Team	**Required** Coordination and follow up of medical treatment Case manager will maintain regular communication with client's HIV medical provider (case consultation will take place, at a minimum, every 6 months) Case manager will assist with scheduling appointments, following up on missed appointments and adherence planning	**Not Required** **Best Practice:** Assistance is provided as needed	**Not Required** **Best Practice:** Assistance is provided as needed	**Not Required** **Best Practice:** Assistance is provided as needed
Transition between Tiers	Movement to Non-MCM can take place at any time after the client is medically stable. Movement to BCM or MOSS can take place after all of the following have been met: ▪ The client has received a minimum of 3 months on MCM or non-MCM. ▪ All required sections of the	Movement to a higher tier can take place at any time. Movement to a lower tier can take place after all of the following have been met: ▪ The client has received a minimum of 3 months on MCM or non-MCM. ▪ All required sections of the Annual Assessment are completed.	Movement to a higher tier can take place at any time. Movement to MOSS can take place after all of the following have been met: ▪ The client is no longer in need of financial assistance including BDAP and HOPWA. ▪ Acuity Scale indicates the	Movement To a higher tier can take place at any time. All clients must receive MCM or Non-MCM for a minimum of 3 months before transitioning to MOSS Case manager will use the Acuity Scale to document transition.

	Annual Assessment are completed. ▪ Acuity Scale recommends BCM or indicates client is eligible for MOSS Case manager will use the Acuity Scale to document transition.	▪ Acuity Scale recommends BCM or indicates the client is eligible for MOSS Case manager will use the Acuity Scale to document transition.	client is eligible for MOSS. All clients must receive MCM or Non-MCM for a minimum of 3 months before transitioning to BCM Case manager will use the Acuity Scale to document transition.	