

STATE OF ARIZONA

RYAN WHITE PART B

CONTRACTORS AND CASE MANAGEMENT GUIDE

**The purpose of the Ryan White Care Act, as stated` in legislation, is to “provide for the development, organization, coordination and operation of more effective and cost-effective systems for the delivery of essential services to individuals and families with HIV disease”. Programs should reach HIV+ persons with programs that make a difference at a reasonable and acceptable cost.**

ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

OFFICE OF DISEASE INTEGRATION AND SERVICES

RYAN WHITE PART B

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This document is a compilation of information from ADHS Ryan White Part B, HRSA

and The AIDS Institute with input from our Providers

STATE OF ARIZONA RYAN WHITE PART B

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**HRSA Guiding Principles for CARE Act Programs**

The CARE Act addresses the health needs of persons living with HIV disease (PLWH) by funding primary health care and support services that enhance access to and retention in care. The following principles were crafted by HAB to guide CARE Act programs in implementing CARE Act provisions and emerging challenges in HIV/AIDS care:

**Revise care systems to meet emerging needs**.

The CARE Act stresses the role of local planning and decision making—with broad community involvement—to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems (*e.g.*, capacity development to expand available services) to meet the needs of emerging communities and populations. A priority focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PLWH who know their HIV status and are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services—directly or through appropriate linkages.

**Ensure access to quality HIV/AIDS care.**

The quality of HIV/AIDS medical care—including combination antiretroviral therapies and prophylaxis/treatment for opportunistic infections—can make a difference in the lives of PLWH. Programs should use quality management programs to ensure that available treatments are accessible and delivered according to established HIV-related treatment guidelines.

**Coordinate CARE Act services with other health care delivery systems.**

Programs need to use CARE Act services to fill gaps in care. This requires coordination across CARE Act programs and with other Federal/State/local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS-related services within managed care plans (particularly Medicaid managed care).

Based on HRSA materials dated April 2012; Ryan White Part B providers who provide services covered by Medicaid must be a Medicaid provider. The Ryan White HIV/AIDS Program legislation, Section 2604(g), describes these as “any such service that is available pursuant to the State plan approved under title XIX of the Social Security Act for the State.” This is related to use of Ryan White funds being used as payee of last resort. In a situation where a client may see more than one Ryan White provider; there should be notification between the agencies, coordination of services delivered by the two agencies and written documentation of the reason for dual case management and the services each agency will provide in enough detail that there can be no question about the need for services from each agency and that the agencies are providing different, non-duplicated services.

**Evaluate the impact of CARE Act funds and make needed improvements.**

Federal policy and funding decisions are increasingly determined by outcomes. Programs need to document the impact of CARE Act funds on improving access to quality care/treatment along with areas of continued need. Programs also need to have in place quality assurance and evaluation mechanisms that assess the effects of CARE Act resources on the health outcomes of clients.

**LINKAGE TO CARE**

When Congress reauthorized the CARE Act in 2000, it included new requirements intended toexpand the number of people receiving services through certain sections of the law. The newlanguage requires agencies funded under Title I and Title II of the CARE Act to maintainrelationships and linkages with “key points of entry” to the local health care system. Thegoal: to reach individuals who are either newly diagnosed with HIV or who know their HIV

status but are not in care. HRSA requires that the relationships be “documented through contract language requiring providers to establish ongoing relationships with the local points of entry.

A useful tool for documentation is a Memorandum of Understanding (MoU) or Memorandum of Agreement (MoA). A MoA is a [document](http://en.wikipedia.org/wiki/Document) describing a [bilateral](http://en.wikipedia.org/wiki/Bilateralism) or [multilateral](http://en.wikipedia.org/wiki/Multilateral) agreement between parties. It expresses a convergence of will between the parties, indicating an intended common line of action. It is often used in cases where parties either do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.When an agreement is made with another provider, including Ryan White providers; there must be no duplication of services since federal regulations prohibit paying for duplicate services. In these situations there should be notification between the agencies, coordination of services delivered by the two agencies and written documentation of the reason for dual case management and the services each agency will provide in enough detail that there can be no question about the need for services from each agency and that the agencies are providing different, non-duplicated services. A copy of this agreement should be provided to ADHS for approval by ADHS and HRSA prior to starting services.

**Potential Linkage Partners**

Social service providers

\_ Adult and juvenile detention facilities

\_ HIV counseling and testing sites

\_ Homeless shelters

\_ Substance abuse treatment programs

\_ Local nonprofit HIV prevention agencies

\_ Public health departments

Health care providers

\_ Community health centers

\_ Detoxification programs

\_ Family planning centers

\_ Comprehensive hemophilia diagnostic and treatment centers

\_ Federally qualified health centers

\_ Health services for the homeless

\_ Migrant health centers

\_ Mental health programs

\_ Sexually transmitted disease clinics

\_ Emergency rooms

Ryan White HIV/AIDS Program funds are intended to support only the HIV-related needs of eligible individuals. Grantees and funded contractors must be able to make an explicit connection between any service supported with Ryan White HIV/AIDS Program funds and the intended recipient's HIV status, or care-giving relationship to a person with HIV/AIDS.

**RYAN WHITE GUIDANCE FOR PART B CONTRACTORS**

This guidance sets forth requirements related to AIDS Institute Ryan White Part B contracts as stipulated in the Ryan White HIV/AIDS Treatment Extension Act and as mandated by HRSA policy. The following information provides guidance for contractors in developing budgets and work plans. Ryan White contracts mustadhere to these requirements. This guidance includes information on allowable services, client eligibility, time and effort reporting, administration, and payer of last resort/revenue requirements. The service categories are limited locally by the State of Arizona Grant, the findings of the Arizona Statewide Needs Assessment and Contractor funding request. ADHS requires that all Ryan White Part B clients first apply for ADAP, this includes all those who may have private insurance including Medicare Part D.

**Ryan White Service Categories**

Ryan White policy limits the persons eligible for Ryan White services and limits the services that are allowable with Ryan White funds. Activities supported and the use of funds appropriated under the policy must be in accordance with legislative intent, federal cost principles, and program-specific policies issued by the federal Health Resources and Services Administration (HRSA). HRSA policy related to Ryan White Part B states that no service will be supported with Ryan White funds unless it falls within the legislatively defined range of services. In addition, the law stipulates that funds will not be used to make payments for any item or service to the extent that payment can reasonably be expected to be made by sources other than Ryan White funds. HRSA policy states that grantees and their contractors must recognize that Ryan White funds are to be considered dollars of last resort and must make reasonable efforts to secure other funding instead of Ryan White funding whenever possible. In conducting program planning, developing contracts, and overseeing programs, you must comply with legislative intent and HRSA policy regarding allowable services and payer of last resort requirements. White Ryan White does fund other services, the services listed here are only those provided by ADHS.

**CORE SERVICES** Core services should be 75% of ADHS Ryan White Service Dollars.

**Outpatient/Ambulatory medical care (health services)**

OPA 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. Care must be provided by a professional certified and licensed in their field. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment 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 carefor 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 therapy. Outpatient/Ambulatory can also provide funds for vision care that include ophthalmic and optometric services provided by licensed professionals. A treatment plan showing relation to HIV/AIDS for ophthalmic and optometric care must be signed by doctor providing the service and approved by ADHS, prior to billing. It can also be used for low-vision training by authorized professionals. Funding will not be provided for services in a hospital, emergency room or any other in-patient facility. All providers of medical service are required to be a Medicaid agency and Medicaid should be the payee of choice for client costs.

Laboratory tests integral to the treatment of HIV infection and related complications are part of Outpatient and Ambulatory Care. Lab work must be requested by a licensed provider.

**Medical case management services (including treatment adherence**)

The Medical Case Manager should ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staffs that are part of the clinical care team. The Medical Case Manager should be involved in clinical care team meetings for the client’s benefit. The coordination and follow-up of medical treatment 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/AIDS 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 contact, and any other forms of communication. A Medical Case Manager should be knowledgeable in HIV;

including; care, treatment and testing. A Medical Case Manager should be able to assist and advocate for a client in understanding their medical care. Medical Case Managers can provide all services that a Non-Medical Case Manager provides. If a client has a medical provider with a Medical Case Manager on site, the client’s medical case management would best be handled by that Medical Case Manager to ensure continuation of care within the treatment team. If that agency does not provide support services, those may be provided by another Ryan White agency that specializes in Support Services.

**Oral Health**

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and other trained primarycare providers. Providers must meet the State of Arizona licensing standards. In Arizona, dental care is administered by Delta Dental and Part B funding will help with purchasing a services limited to $3,500. A treatment plan is required; showing relation to HIV, cost and a time line which is signed by the Dentist. If a client goes over the $3,500, an additional treatment plan is required; showing relation to HIV, cost and a time line which is signed by the Dentist. This request must be provided to and approved by ADHS prior to payment. Documentation for all clients must be in the client file showing that the client has received dental care, at least twice a year.

**Health Insurance Premium and 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 purchasing health insurance that provides comprehensive primary care and pharmacy benefits for low income clients that provide a full range of HIV medications, paying co-pays and deductibles on behalf of the client, and providing funds to contribute to a client’s Medicare Part D true out-of-pocket (TrOOP) costs. Part B funding must be used to supplement, NOT supplant existing federal, state, or local funding for Health Insurance Premium and Cost-Sharing Assistance. All clients must apply for ADAP to determine the least expensive method for drug costs.

**Early Intervention Services**

EIS programs have as their principal purpose identification of people who KNOW their status so that they may become aware of, and may be enrolled in care and treatment services, EIS is NOTHIV counseling and testing or HIV prevention education. EIS funding is for follow up lab work and an initial medical visit after an HIV+ diagnosis. Early Identification of Individuals with HIV/AIDS (EIIHA) is linked to EIS but may provide funding for testing of those who do not know their HIV status but are considered high risk. EIIHA services shall only be provided at specific points of entry defined as health care access points frequently used by traditionally underserved HIV-positive individuals to help meet their medical and social service needs. EIIHA must be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

High risk is considered injection drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV+ persons, and MSM or heterosexual persons who themselves or whose sex partners have had multiple partners since the last HIV test. ADHS requires documentation showing that the services are not duplicating efforts of other agencies testing for HIV in the same geographical area and that testing is limited to those who meet the definition of high risk. A proposal to provide services for EIIHA must be provided in writing to ADHS and should include strategy, plan and supporting documentation. It should also show that any testing provided is not a duplication of services already available. Approval must be given by ADHS and HRSA prior to the start of the proposed program. Provision of EIIHA must be coordinated with HIV prevention efforts and programs and providers of prevention services.

The contractor must document for both EIS and EIHHA:

* Health Education is provided to those that test.
* That counseling is provided to those testing.
* What referrals for care and services are provided to those that test.
* The Linkage of Care that is used.

**Mental health services for HIV+ persons.** Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by mental health professionals licensed by the State of Arizona to practice within the boundaries and scope of their respective profession. This includes Psychiatrists, Psychologists, Psychiatric Nurse Practitioners, Masters prepared Psychiatric Registered Nurses, and Licensed Clinical Social Workers. A single therapy session to determine the need of the client may be billed to Ryan White without prior authorization. The purpose of this meeting is to allow the mental health professional to develop a treatment plan. To receive additional care, the treatment plan, detailing care, cost and the number of sessions, signed by the mental health provider, needs to be approved by ADHS. Support groups are not considered mental health unless they are provided by a licensed mental health provider. The provider leading the support group should submit an agenda and expected number of groups to ADHS with a copy of their license for billing approval. ADHS does not provide funding for support groups lead by non-licensed professionals.

**Substance abuse services-outpatient**

Substance abuse services are 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. Prior to services being provided, the client should have a treatment plan showing length of treatment, cost and dates of service if they are to be billed to Ryan White. The treatment plan should be signed by the licensed substance abuse provider and approved by ADHS. Substance abuse services should be limited to:

* Pre-treatment/recovery readiness programs
* Harm Reduction
* Mental Health Counseling to reduce depression, anxiety and other disorders associated with substance abuse.
* Outpatient drug free treatment and counseling.
* Opiate Assisted Therapy
* Relapse prevention

**SUPPORT SERVICES**

Ryan White Dollars for Support Services are limited to 25% of available ADHS funding.

Support services are only to be provided to individuals with HIV/AIDS to achieve medical outcomes related to their HIV/AIDS clinical status.

**Case management (non-medical)**

Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. Non-medical Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed support services. A Case Manager will assist a client with applying for benefits and facilitates referrals to help the client meet service needs. In accordance with HRSA <http://hab.hrsa.gov/manageyourgrant/pinspals/incarceratedpersons0704.html>, this includes transitional case management for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning, or who are in the correctional system for a brief period, which would not include any type of discharge planning. ADHS requires a written plan be submitted for provision of case management to incarcerated persons to confirm compliance to HRSA standards, this should be approved prior to implementing the program. All case management services must be provided in accordance with ADHS and HRSA policies. The goal of case management is to facilitate clients’ autonomy to the point where they can obtain needed services on their own.

**Emergency financial assistance (EFA)**

EFAis the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries and food vouchers) and medication when other resources are not available. The allocation of Ryan White HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time. Client must have been denied for assistance through all applicable agencies, charities, friends, family, etc., prior to applying for EFA. Client must have supporting documentation to support their request; this may include bills, fees, eviction notices, doctor notes, etc. The Case Manager will chart EFA requests in progress notes in the client’s case file. EFA may not be provided more than once each 6 month renewal period for any one service area. If EFA is needed for the same service more than once in a 6 month renewal period, approval must come from ADHS and it must be medically related and documented to show good cause.

**Treatment adherence counseling**

Treatment adherence is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting. Treatment adherence not provided by the Case Manager must be provided by a licensed provider.

**Food bank/home-delivered meals**

This includes the provision of actual food or meals. Prior to providing a food box, a client should be referred to local agencies that provide food assistance to maintain Ryan White as payer of last resort. However, the primary focus of this service is to provide home delivered meals and food to clients who are home bound or need additional nutrition due to HIV related illness. Clients may not be provided finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies can be included in this item. Vouchers to purchase food may be used but the client should provide a receipt showing allowable purchases were made. Food boxes including hygiene and cleaning supplies may be provided to a client once every 6 month renewal period without medical documentation of need. Medical necessity for more frequent assistance should be related to serious health issues including wasting and food restrictions that have a serious health impact. Documentation should come from a licensed prescribing provider who is directly involved with the client’s medical care. It should state that the client needs additional nutrition and the related, specific HIV related health concern. Documentation should be in the client file showing medical necessity for any one client needing food boxes or home delivered meals more than once during a 6 month renewal period. If an agency has a food pantry on site, good cause must be shown for food boxes.

**Housing services**

Housing Servicesare the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services. Prior to using Ryan White housing services, a client should be referred to local agencies that provide housing assistance and to HOPWA, if they are available in the client’s area. The need for housing services must be documented in the client file; a letter denial or delay from local agencies, a document of how the move is medical necessity and if the move is permanent, how the client will pay for housing in the long term. For services beyond one week, authorization from ADHS is required. Funding may never be used to pay a mortgage or rent.

**Medical transportation services**

Transportationincludes conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. HRSA states it as “Funds may be used to provide transportation services for an eligible individual to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care.” Medical Transportation cannot be provided to Medicaid or AHCCCS clients as these programs provide medical transportation, up to 100 miles without prior authorization. Medical Transportation must be based on the lowest cost option and health; a single day bus voucher should be used as the first option, unless the client has significant health issues and then a taxi voucher can be provided. If a client lives in a community with public transportation and chooses to use a private vehicle, transportation costs will not be reimbursed. If a client has a car and lives outside a community that has public transportation and has no other options for a closer Ryan White health care provider, gas vouchers may be provided. The vouchers are limited to $5 per 10 miles with a limit of up to 50 miles at $25. Transportation for other Support Services must be those services that have documentation provided by and signed the client’s physician that the client has support needs that are medically necessary related to a specific health issue, not just HIV status.

**ADMINISTRATIVE COSTS**

Ryan White dollars for Administration cannot exceed 10% of the budget.

**Personnel**

Administrative costs associated with the 10 percent administrative cap include the following:

* Development of funding applications
* Receipt and disbursal of program funds
* Development and establishment of reimbursement and accounting systems
* Preparation of routine programmatic and financial reports.
* Compliance with grant conditions and audit requirements
* All activities associated with the contract award procedures, including the development of requests for proposals, contract proposal review activities, negotiation and awarding of contracts, development and implementation of grievance procedures, monitoring of contracts through telephone consultation, written documentation or on-site visits, reporting on contracts, and funding reallocation activities.
* Quality Management

**Other Operating**

Other Operating costs include materials and supplies, space and occupancy and general operating services. Costs related to space needed for the delivery of Contract services are allowable expenses. Space costs include the expense of a facility and other expenses directly related to the operation of the facility. Space costs, however, do not include the purchase or major modification of land or facilities. The costs of materials and supplies, necessary for the delivery of Contract services, are allowable budgeted expenses. Such costs should be calculated by deducting from the purchase price, all cash and trade discounts, rebates, and allowances to be received by the Provider agency.

**Indirect Costs**

Indirect costs - Indirect costs are those incurred for a common or joint purpose benefiting more than one cost objective or activity and not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. If using indirect cost as part or all of its 10% administrative costs, the Contractor must provide an HHS-negotiated, HRSA-approved Cost Allocation Plan and an approved Indirect Cost letter.

**A PARTIAL LIST OF UNALLOWED SERVICES**

Ryan White Part B funds cannot be used to support services that are not included on the above list. Examples of services that are not allowable include: Please note this list is not conclusive, if you are not sure if an item is covered, contact ADHS.

* HIV prevention/risk reduction for HIV-negative individuals.
* HIV counseling and testing.

(The above may be funded for a ADHS/HRSA approved EIS / EIIHA program.)

* Syringe exchange programs*.*
* Employment, vocational rehabilitation, or employment-readiness services.
* Art, drama, music, dance, or photography therapy.

• Social, recreational, or entertainment activities. Ryan White funds cannot be used to support amusement, diversion, social activities, or any costs related to such activities, such as tickets to shows, movies or sports events, meals, lodging, transportation, and gratuities. Movie tickets or other tickets cannot be used as incentives. Ryan White funds cannot support parties, picnics, structured socialization, athletics, etc.

* Non-client-specific or non-service-specific advocacy activities.
* Services for incarcerated persons, except transitional case management.
* Costs associated with operating clinical trials.
* Funeral, burial, cremation or related expenses.
* Direct maintenance expense, loan payments, insurance, or license and registration fees associated with a privately owned vehicle.
* Local or State personal property taxes.
* Criminal defense or class action suits unrelated to access to services eligible for funding under Ryan White.
* Direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers or similar programs, which may only be exchanged for a specific service or commodity (e.g., food or transportation), must be used to meet the need for such services. Voucher programs must be administered in a manner which assures that vouchers cannot be readily converted to cash.
* Inpatient medical services and Emergency Room care.
* Clothing.
* Installation of permanent systems for filtration of all water entering a private residence.
* Professional licensure or to meet program licensure requirements.
* Broad-scope awareness activities about HIV services which target the general public.
* Fund raising.Federal funds cannot be used for organized fund raising, including financial campaigns, solicitation of gifts and bequests, expenses related to raising capital or contributions, or the costs of meetings or other events related to fund raising or other organizational activities, such as the costs of displays, demonstrations, and exhibits, the cost of meeting rooms, and other special facilities used in conjunction with shows or other special events, and costs of promotional items and memorabilia, including gifts and souvenirs. These costs are unallowable regardless of the purpose for which the funds, gifts or contributions will be used.
* Transportation for any purpose other than acquiring medical services or acquiring support services that are linked to medical outcomes associated with HIV clinical status. Transportation for personal errands, such as grocery shopping, other shopping, banking, social/recreational events, restaurants, or family gatherings is not allowed.
* Pediatric developmental assessment and early intervention services, defined as the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children.
* Permanency planning defined as the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.
* Voter registration activities.
* Costs associated with incorporation.
* Herbal supplements/herbal medicines.
* Massage and related services.
* Reiki, Qi Gong, Tai chi and related activities.
* Relaxation audio/video tapes.
* Yoga, yoga instruction, yoga audio/video tapes, yoga/exercise mats.
* Buddy/companion services.
* International travel.
* Construction.
* Lobbying expenses
* May not be used for staff training that is not specific to HIV.
* Property Taxes.
* Over the Counter Medications.
* Child Care.
* Costs associated with pet care.
* Acupuncture.

**REVENUE/PAYER OF LAST RESORT**

In order to ensure that Ryan White funds are payer of last resort, contractors must screen clients for eligibility to receive services through other programs (e.g., Medicaid, Medicare, VA benefits, private health insurance, other Grants and local funding sources), reassess client eligibility every 6 months to verify continued qualification for Ryan White services, and document client eligibility. Contractors must have policies and procedures in place addressing these screening requirements. Contract managers will review these policies and procedures as well as documentation of client eligibility during monitoring visits.

**CLIENT ELIGIBILITY**

**ADHS ELIGIBILITY REQUIREMENTS**

The standards and guidelines for the five (5) eligibility and documentation requirements to receive HIV/AIDS medical and support services (including case management services) provided by the Ryan White Part Program must be documented on the Intake/Eligibility Form with the appropriate back-up information and included in the file.

**Proof of HIV Status**:

* A confirmed positive HIV antibody test
* A positive HIV direct viral test such as PCR or P24 antigen
* A positive HIV viral culture
* A detectable HIV viral load or viral resistance test.
* A test result generated by a licensed medical provider.
* Letter of Medical Necessity: A signed letter or medical progress note from a licensed provider with identified agency/medical provider logo stating that the client has HIV/AIDS.
* Copy of the ADAP Application: A copy of the ADAP application signed by a medical provider.
* A verified ADHS State No.

**Screening for Medicaid and Other Services Programs** (Payee of Last Resort)

There are numerous local, state and federal public benefit and entitlement programs which can serve people with HIV/AIDS. Screening persons for participation and enrollment in these

programs is a part of the eligibility requirement. An individual may not be eligible for the Department's services if he or she is already receiving benefits from other programs; especially where payment of services is made by third party payers, including private insurance, prepaid health plans, Medicare, Medicaid or other state or local entitlement programs.

**Client Financial Assessment** (Assets and Income)

A Ryan White Client must have annual family income that is less than or equal to 300% of the Federal poverty level.

A family is defined as:

* A group of individuals residing together who are related by birth, marriage, or adoption; or
* An individual who: Does not reside with another individual; or
* Resides only with another individual or group of individuals to whom the individual is unrelated by birth, marriage, or adoption.

***Earned Income*** is considered:

* Wages
* Commissions and Fees
* Salaries and tips
* Self-Employment
* Profit from Rent
* Any other monetary payments for work performed or rental of property.

***Unearned Income*** is considered

* Unemployment Insurance
* Worker’s Comp
* Disability Payments
* SSI/SSDI
* TANF/Public Assistance
* Insurance or Annuity Payments
* Retirement or Pension Payments
* Strike benefits
* Training stipends
* Child Support
* Alimony
* Military family allotments
* Regular support from those not living in household
* Investment income
* Royalty payments
* Periodic payments from trusts or estates
* Other monetary payments

**Documentation**

For each job held by an adult in the family unit:

* Paycheck stubs from the 30 calendar days before the date of application, or
* A statement from the employer listing gross wages for the 30 calendar days before the date of application; From each self-employed adult in the family unit, documentation of the current net income from self-employment, such as:
* An income tax return submitted for the previous tax year to the U.S. Internal Revenue Service or the Arizona Department of Revenue;
* The Internal Revenue Service Forms 1099 prepared for the previous tax year for the self-employed adult in the family unit;
* A profit and loss statement for the self-employed adult's business; or
* Bank statements from the self-employed adult's checking and savings accounts;
* A letter from each entity providing public assistance to an adult in the family unit, describing payments from public assistance;
* A letter from an entity providing a monetary award to an adult in the family unit to cover educational expenses other than tuition, describing the monetary award; and

If the applicant has no source of regular monetary payments and is unable to provide any of the documentation specified above a document must be completed and signed within 30 calendar days before the date of application, containing:

* Information completed by the applicant or the applicant's representative stating whether:
* An adult in the applicant's family unit receives money from intermittent work performed by the adult in the family unit for which no paycheck stub is received and, if so, the average monthly earnings, and the adult's occupation;
* The applicant is homeless or living in a shelter;
* The applicant is receiving assistance from another individual; and
* The applicant has another source of assistance for obtaining food, water, housing, and clothing, and, if so, an identification of the source;

If the client is here illegally or is a migrant worker, he or she may still be employed. Efforts should be made to secure documentation that the client does not have an income (e.g., letter from friend, family member). The documentation for a person who states that he or she has had little or no income coming into the household for more than a few months must reflect how food, shelter, and utilities are being managed.

**Arizona Residency Verification**

A person must be living in the state of Arizona at the time of the eligibility determination and should meet Arizona residency requirements. Resident means an individual that has a current place of habitation in Arizona and lives in Arizona as other than a tourist. Proof can be provided by:

* Public Assistance documents within 60 days
* Social Security Administration or Department of Veteran’s Affairs documents.
* Property tax statement
* Homeowner’s Association Fees within 60 days
* Current Lease Agreement
* Mortgage Statement-the most recent year.

If the above are unavailable, then two items from the following list should be provided:

* Utility bill within 60 days
* Tax Bill
* W-2
* Pay Check Stub 60 days
* Bank Statement 60 days
* Current Arizona Driver’s License
* Current Arizona Vehicle Registration
* Current Arizona ID Card
* Current Tribal Enrollment
* Current US Immigration, ID Card

If only one item in the above list is available, one may be substituted by one of the following:

* Current Non-permanent housing letter
* Community Service Organization verifying homeless status and AZ residency within 2 weeks of application.
* Credit Card or other bill within 60 days
* Current Vehicle Insurance card
* Current Voter Registration
* Current Case Manager Statement based on home visit
* Primary Care Provider Statement within 2 weeks of application

Persons who spend the winter in Arizona and maintain their permanent residence elsewhere should arrange for needed treatment through resources available in their home state.

Citizenship of the United States is not an eligibility requirement. Persons do not have to document citizenship or immigration status in order to be eligible for services

**Willingness to Provide Appropriate Information**

Based on your agency policy, you may refuse services to a client that is non-compliant in care resulting in not keeping documentation current. Non-compliant would also be related to a client that does not show up for care or case management but wishes to receive support services.

Consideration on the personal safety of staff and other clients should also be considered.

**CASE MANAGEMENT GUIDELINES**

Individuals living with HIV infection are often faced with a multitude of issues that, if not addressed in a timely manner, can result in negative health consequences. These issues include, but are not limited to, medical care, transportation, emergency housing, food, support groups, mental health counseling, etc. Obtaining these services is often difficult for these individuals in light of the complex, fragmented and usually unfamiliar service delivery system. A person may receive assistance in securing these critical services through what is commonly referred to as “case management.” The U.S. Department of Health and Human Services, HIV/AIDS Bureau, Health & Resources Service Administration (HRSA) defines case management as: “A range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client’s and other family members’ needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Case Management may only be provided to a non-Ryan White qualifying client at the initial meeting to determine eligibility. Key activities include, but may not be limited to:

* Initial comprehensive assessment of the client’s needs and personal support systems.
* Development of a comprehensive, individualized service plan.
* Coordination of the services required to implement the plan.
* Client monitoring to assess the efficacy of the plan.
* Timely re-evaluation and revision of the plan every six months.
* Client-specific advocacy and/or review of the utilization of services.

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

**Case Manager Qualifications**

Preferred qualifications for a Case Manager include aBachelor's or Master's degree in health, human or education services and one year of case management experience with HIV+ persons, and/or persons with a history of Case Management experience with mental illness, homelessness, or chemical dependence. Alternately, a Case Manager may possess an Associate's degree in health or human services, licensure as an RN or LPN, or certification as a certified alcohol and substance abuse counseling, and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence.

**Case Management Supervisor Qualifications**

Preferred qualifications for a Case Management Supervisor include a Master’s degree in Health or Human Services, one year of supervisory experience, and one year of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence. Alternately, a Case Management Supervisor may hold a Bachelor's degree in Health or Human Services, and have two years of supervisory experience and two years of case management experience with HIV+ persons, and/or persons with a history of mental illness, homelessness, or chemical dependence.

**Medical Case Management**

Medical Case Manage is a range of client-centered services that are designed to enhance access to andretention in medical care for eligible people living with HIV. Medical care is defined as

primary medical care (outpatient and ambulatory services), specialty care, mental heath

& substance abuse treatment, oral heath, HIV medications, HIV medication adherence

services, health & risk reduction education & related services, early intervention

services, home health care, medical nutrition therapy, hospice services, and home &

community-based health services. The medical case manager coordinates clinical &

support services to the extent that clients maintain continuity of care & appropriate

referrals for care. Medical case managers perform their activities in consultation with & as part of a clinical team in a health care setting (e.g., case conferences). Medical care is defined as primary medical care (outpatient and ambulatory services), specialty care, mental health & substance abuse treatment, oral heath, HIV medications, HIV medication adherence services, health & risk reduction education & related services, early intervention services, home health care, medical nutrition therapy, hospice services, and home & community-based health. Solicit prior partner names during sessions when appropriate, follow state reporting requirements when names are given. A Medical Case Manager may also be involved in the duties of a Non-Medical Case Manager.

**Goals**:

The goal of medical case management services is to enhance access to and retention

in medical care for eligible people living with HIV to a range of client-centered services

and to advocate for the client to ensure access to and retention in culturally competent

core medical and other services.

**Non-Medical Case Management**

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. Solicit prior partner names during sessions when appropriate, follow state reporting requirements when names are given.

**Goals:**

The goal of non-medical case management is to assist the client to become as self-sufficient as possible in their daily life.

**Case Management Roles and Responsibilities**

* Maintain a professional therapeutic relationship with the client.
* Conduct an intake into care, including an initial assessment of client strengths and needs and the development of a comprehensive service care plan.
* Conduct ongoing assessment of client needs incorporating client feedback and input at least every six months.
* Conduct ongoing service planning, including re-evaluation and updating.
* Provide direct provision of appropriate services.
* Negotiate realistic goals with client within realistic time frames.
* Monitor client’s progress to meeting established goals of care.
* Advocate for the client to ensure access to appropriate, culturally competent services.
* Make referrals and link clients to other appropriate resources. Document referrals.
* Create and maintain resource and referral networks.
* Follow up with client’s service provider regarding referrals.
* Coordinate service delivery in a timely manner
* Document activities regularly in progress notes.
* Define role expectations and tasks of both the case manager and client throughout the entire case management service agreement.
* Operate with an exchange of dignity and respect between the case manager and client.
* Protect the oral, written and electronic confidentiality of the client.
* Participate in case conferences to sustain or improve client quality of life.
* Inform the client of agency and grievance policies and procedures.
* Follow up with client’s service provider regarding referrals.
* Foster independence by reviewing the assessed need at least every six months.

**Service Delivery**

The case manager will inform clients that they are eligible for case management services free of charge. If there are multiple Ryan White providers in the same service area, offering the same services; the client should be informed they have the right to choose the agency and Case Manager that best meets their personal needs. The client’s manager must notify the client that they may not receive duplicate services from more than one agency. The case manager will conduct a face-to-face assessment of the client’s needs.

**INITIAL CONTACT AND CLIENT ELIGIBILITY**

The personal contact and client eligibility information obtained during the intake/eligibility process is not to be confused with the initial comprehensive assessment which is conducted by a qualified case manager as one of the key activities of case management services.

The objectives of the intake and eligibility determination are to:

* Collect basic client information to facilitate client identification and client follow-up
* Inform the client of services available and what the agency can offer them.
* Establish client eligibility for services
* Refer for case management and other services and programs if ineligible

Clients are eligible for services when the verification of Ryan White documentation is completed. Additional Case Management services can be provided at a later date.

**Client Assessment and Intake**

A client assessment must include, but may not be limited to:

* financial status
* name of client primary medical provider
* Viral Load (VL) & CD4 test results
* medical/insurance status
* psychosocial supports
* transportation barriers
* basic needs
* nutritional status
* housing
* HIV medication adherence
* need for referrals to other services & outcome of referrals

The list is expanded for Medical Case Managers to include documentation related to medical, substance abuse and mental health history. The assessment should be reviewed with the client for the purpose of developing a mutually agreed upon Service Plan. The information should be updated at least every six months. If a client cannot meet with the case manager at an agency, the case manager should attempt to meet the client at a location accessible and appropriate for the client (e.g., home, shelter, with family, etc.)

**Service Plan / Care Plan**

The case manager will develop a Service Plan with the client to insure that the identified needs are addressed for every client enrolled in case management. Case managers must ensure that all client needs are identified and prioritized so that the most important services for clients are made available as soon as possible. Plans should incorporate client needs, preferences, and the client’s strengths and limitations. Initial Service Plans should be completed at the first face-to-face meeting with the client. HIV, income and residency documentation must be obtained prior to providing Ryan White funded services. The Care Plan must be updated every six months.

**Progress Notes and CAREWare**

* The person making the progress note entry must sign or initial and date each entry.
* Black ink should be used in case notes.
* Fill in the blanks on all forms or note N/A to show that the form is completed.
* Entries in client files should be dated.
* All activity with a client must be noted in the client case notes.
* Type of encounter (e.g., face to face, telephone, emails, etc.) should be documented.
* The duration of the contact should be documented.
* The case manager will document the progress on meeting the goals addressed in the Service Plan in the clients record/progress note section.
* The case manager will document efforts to contact the client as needed (e.g., to update client information, reassess service care plan, assess completion of referral, etc.)
* The case manager should not leave blank spaces between progress notes.
* Each meeting or service delivery must be documented and dated in CAREWare as well as the client file.
* Referrals should be documented in CAREWare.

**Suggested File Organization**

A file binder with 3 sections works best. Documents should be placed in the binder so that the most frequently used documents are on top and easy to access. Files should be kept for 5 years.

Section 1: Left Side: Intake / Client Information (update at 6 months)

Verification of HIV Status (current)

Verification of Residency (current)

Verification of Income (current)

Consent to Case Management (current)

Grievance Policy (current)

Client Rights and Responsibilities (current)

Right Side: Individual Service Plan / Care Plan

Client Acuity

Progress Notes

Correspondence from Client

Section 2: Left Side: Referral List

Release of Information Forms

Eligibility or Denial Letters from referral agencies

Right Side: Budget Worksheet for Client

Bills submitted and paid for client

Documentation of payee of last resort for bills

Section 3: Left Side: Dental Paperwork

Right Side: Expired documents from section 1-Left side

**STANDARD CASE MANAGEMENT DOCUMENTATION**

All provider agencies who offer case management services must have a client record system that includes consistent and standardized ways of collecting and maintaining information including, but not limited to, client demographics, assessments, service plans, treatment/services provided, client response to services, updates, treatment goals, and verification of Viral Load and CD4 test results. **Information must be updated every (6) six months.** Contents of the client record shall be protected within the parameters of State and federal laws.

* Check List to track documentation completion status.
* Consent to Case Management - Client Rights and Responsibilities
* Grievance and Appeals Process
* Agency Privacy Practice or HIPAA information from AZDHS
* HIV Documentation; VL/CD4
* Income Documentation
* Identity/Residency Verification
* Release of Information
* Intake Application
* Consent for Treatment/Case Management
* Care Plan / Comprehensive Assessment
* Self Sufficiency / Acuity Worksheets
* Referral Forms

**Confidentiality Form (Update every 6 months)**

The clients’ right to privacy will be safeguarded and respected in accordance with federal and State laws. All clients must be given the opportunity to read, as well as understand, the confidentiality agreements between client and the agency. The client has a right to know for what period of time the disclosure will occur and what safeguards are in place against unauthorized disclosure.Communication made on the client’s behalf should safeguard the client’s right to privacy (face-to-face conversations, telephone communications, faxing or e-mailing client identifying information). Current Release of Information forms must be in place for all client focused communication with other providers. A client should also sign a ROI for ADHS to facilitate reports and billing. Release of Information forms must be HIPAA compliant and include:

* A description of the information to be released
* Name of the Individual
* Name of the recipient
* Purpose of the disclosure
* Expiration Date
* Signature and Date signed.
* A statement informing the client they have the right to revoke the release.

**Grievance Procedures (Update every 6 months)**

Case management providers must establish and follow a system of internal agency procedures through which clients may present grievances if services are reduced, suspended, denied, or terminated; or if a client is dissatisfied with the way services are provided. New clients are to be informed of the grievance policies and procedures during the first contact. Clients will be reminded of the grievance policy whenever a problem is identified that may result in a grievance.

**Client Rights and Responsibility (Update every 6 months)**

All clients have the right to be treated respectfully by case management staff. Clients also have a mutual responsibility to work cooperatively and agreeably with case management staff. Clients are provided a copy of their rights and responsibilities once eligible for services. The Client's Rights and Responsibilities Policy should:

* Ensure that the client's decisions and needs drive the case management process
* Ensure a fair process of case review if the client believes he/she has been mistreated, poorly serviced or wrongly discharged from case management services
* Clarify the client's responsibilities which help facilitate communication and service delivery
* Case management agencies must develop and post the Client's Rights and Responsibilities agreement in a conspicuous location in the agency. The client must be provided a copy of this agreement at the time client eligibility has been determined. Eligible clients are provided a copy to sign once enrolled in a case management agency and receiving services.

Applicants should sign a document notifying them of their responsibility to notify the Ryan White provider of any change in their income, residency, health insurance coverage or eligibility for coverage within 30 days at each eligibility evaluation. Failure to notify the Ryan White provider may disqualify them from enrollment in Ryan White.

**OTHER CASE MANAGEMENT AREAS:**

**AIDS Drug Assistance Program** ADHS is responsible for the administration of ADAP for the state of Arizona. ADAP provides access to medications used to treat HIV and prevent the onset of related opportunistic infections to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. Applications and instructions can be found at: <http://www.azdhs.gov/phs/hvstdhpc/adap.htm> ADAP verification is the same as Ryan White Part B; income, residency and HIV status. The ADAP drug formulary may be more extensive and less expensive than that provided by private insurance, Medicaid, VA and IHS. It is due to this fact, that an ADAP application is required for all clients. Additionally, ADAP may be more cost effective than existing client coverage which would qualify it as the payer of last resort with Ryan White funding.

**Screening for Substance Abuse and Mental Health Issues:**

Mental health/Substance Abuse screenings include the use of brief structured instruments or commonly used questionnaires to assess potential health problems. Screenings are designed to determine whether the client presents signs or symptoms of a health problem and if the client should be referred to a professional. Screens are not diagnostic tools and, although typically administered by a mental health professional, may be administered by trained health care professionals in other medical/clinical disciplines.

**Suggested method to determine case load for each Case Manager:**

From experience, it is suggested that the standard case load per case manager is 50. Most clients do not come in on a monthly basis, please use a 3 month average from CAREWare to determine the average number of clients seen a month and the time spend with them. Divide this by the number of case managers that saw these clients. Another formula is to start from a basis of each employee having 160 hours a month available for case management. Over a month:

* How many hours are spent in training in a month?
* How many hours are spent in Treatment Team or Staff Meetings?
* Average time spend with a client each month.
* Average number of clients seen each month.
* Average time traveling to see clients a month.

(Travel should be documented and routed in the most time effective manner if multiple client visits will be made in one day. Documentation should be provided to ADHS.)

* Average time in other duties each month. Document these duties.

The total should give an estimated time available and show the number of clients that can be reasonably seen by a Case Manager. In determining case load, only count active clients.

**Client Termination or Discharge:**

Client termination or discharge will occur for a number of reasons. A final narrative for inclusion in the client file must be completed with the approval of the supervisor before a case is considered closed**.**

The objectives of client termination or discharge are to:

* Appropriately close files for clients no longer wanting or needing case management services
* Ensure a smooth transition for a client to other case management agencies
* Accurately track only clients receiving active case management services
* In all discharge or termination circumstances, the case manager must include a final narrative in the client file relating to the circumstances of the client's termination, transition or dismissal.

A client may be discharged from case management services for any of the following reasons:

* Death
* At the request of the client
* If a client's action put the agency, case manager or other clients at risk
* If client moves out of the service area

In Cases of Death:

* The case manager should be notified of the client's death by the client's family, significant other, direct care provider, legal guardian, or other designated person approved by the client
* The case manager will notify and verify termination of all funded or arranged services and will facilitate or complete billing requirements

In Cases of Client Transfer To Other Case Management Agencies:

Case managers must acknowledge a client's right to choose and change case managers from different case management providers. The client is not obligated to provide an explanation for changing case management agencies. The reasons can include but are not limited to a move from service areas, transportation or case manager conflict.

Files must be held for 5 years following closure prior to being destroyed.

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**TIME LINE FOR CASE MANAGERS:**

|  |  |  |
| --- | --- | --- |
| From Request to First Meeting | 10 Days |  |
| Return Phone Calls | 2 Days |  |
| Intake | Start at first meeting, complete within 30 days. | Updated every 6 months, |
| Eligibility Documentation | At intake – prior to services being provided | Updated every 6 months |
| ADAP Application  /other insurance | At intake | Every 6 months or more if health requires it |
| Needs Assessment  Care/Service Plan  Acuity Screening | Basic-at intake  Care Plan complete within 30 days | Care Plan should be updated every 6 months but it is preferred that it be done at every client meeting. |
| Medical Visit | Within 30 days of intake if client is not currently seeing a physician. | Every 6 months or more if health requires it |
| Access to Other Services | At intake | On going |
| Release of Information | At intake-As needed | Update every 6 months |
| Client Rights/Confidentiality and Grievance Documentation | At intake | Update every 6 months |
| Partner Solicitation | At intake | On going |
| Assessments | Within 30 days, if staff is qualified to administer them. |  |
| Dental Care | Within 3 months if client is not currently receiving care | Updated every 6 months |
| Health Care Coverage | Should be in place within 3 months of intake. |  |

**ADDITIONAL CONTRACTOR INFORMATION**

**Ryan White Contract Monitoring**

**Site Visits**

Site visits will occur at least once a year. These visits will include a review of all aspects of the contract; administration, quality management, case management, MIS and fiscal. ADHS will have access to all requested documents during the requested time frame.

**Monthly Report**

ADHS Ryan White Part B requires monthly billing including MER, CER, General Ledgers and a time management document for each staff member. Client information should be current in CAREWare for the reporting month and support the services being billed for. We will review your monthly reports to see how well you are meeting contracted service and expenditure levels. Monthly reports are due the 15th of each month following the billing month.

**Labor Activity Report (LAR)/Staff Time Logs:**

The contractor should have in place systems to document time and effort of program staff supported by Federal Funds. Time sheets should clearly document the percentage of time each staff person devotes to contract activities and in accordance with the approved budget. Time sheets should show all funding sources for 100% of the staff’s income. If the percentage of effort of contract staff changes during the contract period, contractors must send a request for approval to the State of Arizona Ryan White Part B program prior to implementing the change.

All staff FTE must balance to contractual percentage on a quarterly basis.

**Quality Management:**

Quality Management is required by HRSA and ADHS and is part of the annual review. Legislative requirements in the Ryan White HIV/AIDS Treatment Modernization Act of 2006 require that a grantee "shall provide for the establishment of a clinical quality management program to assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV/AIDS and related opportunistic infection and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services." HAB expects sound quality management programs to be patient focused and should have the following key characteristics:

* Be a systematic process with identified leadership, accountability, and dedicated

resources available to the program;

* Use data and measurable outcomes to determine progress toward relevant, evidenced based benchmarks;
* Focus on linkages, efficiencies and provider, and client expectation in addressing

outcome improvement;

* Be a continuous process that is adaptive to change and that fits within the framework of

other programmatic quality assurance and quality improvement activities (i.e., Joint

Commission on the Accreditation of Hospitals Organization (JCAHO), Medicaid, and

other HRSA Programs); and

* Ensure that data collected are fed back into the quality improvement process to assure

that goals are accomplished and that they are concurrent with improved outcomes.

The Arizona Ryan White Part B Program shall provide for the development and implementation of a quality management program to assess the extent to which HIV health services provided to individuals under the grant are consistent with recent guidelines and treatment of HIV/AIDS and related opportunistic infection(s).

* Monitor to evaluate that services meet or exceed established professional standards and client/patient expectations.
* Ensure that improvements to quality medical care include related supportive services.

**Material Review:**

All written materials, websites/internet materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials must be reviewed and approved by ADHS prior to being put into use. ADHS has established principles on content for HIV/AIDS materials (see below), and requires approval of all applicable materials prior to their distribution and use in any activities funded in any part with Ryan White funds.

* Written materials (e.g., letters, pamphlets, brochures, fliers), audiovisual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, or paintings) should use terms, descriptors, or displays appropriate for the intended audience to understand.
* None of the funds appropriated to carry out this title may be used to provide education or information designed to promote sexual activity or intravenous substance abuse.
* The above statement may not be construed to restrict the ability of an education program that includes the information required to provide accurate information about various means to reduce an individual’s risk of exposure to, or the transmission of HIV.
* Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.
* All materials must either directly contain a health promotion message, an HIV prevention message, or inform about functions or events that ultimately promote the same. For example, a poster advertising a workshop does not need to have a health promotion message as long as the workshop does.
* Information must be accurate, current, and culturally appropriate.

**Sliding Fees**

Contractors must have documented policies and procedures relating to the collection of fees for client services and must make available for review the following:

* Sliding fee discount policy and schedule
* Sliding fee eligibility applications within client files

The sliding fee discount policy and schedule should not allow clients below 100% of the Federal Poverty Level (FPL) to be charged for services. For clients with incomes greater than 100% of FPL, caps should be placed on total annual charges for Ryan White Services (including ADAP) based on a percentage of the client’s annual income as follows:

* 5% for patients with incomes between 100% and 200% of FPL
* 7% for patients with incomes between 200% and 300% of FPL
* 10% for patients with incomes greater than 300% of FPL

**Duplication of Services**

Per HRSA, ADHS and Public Health Policy; most clients need only one case manager. However, there are situations in which more than one agency may be involved; medical and social services for example.  Where there is more than one agency involved, there must be no duplication of services since Federal regulation prohibits Federal funding for duplicate services. A Medical Case Manager would work with the Clinical Team for client education and support in relation to medical care. The Non-Medical Case Manager would provide support services. In these situations there should be notification between the agencies, coordination of services delivered by the two agencies and written documentation of the reason for dual case management and the services each agency will provide in enough detail that there can be no question about the need for services from each agency and that the agencies are providing different, non-duplicated services. When two agencies are funded for the same services, the client should chose the agency that is geographically closest or best fits their needs if more than one agency is in the same area. The documentation should be provided to ADHS for approval prior to services being delivered.

**Annual Report Due Dates**

|  |  |  |
| --- | --- | --- |
| **Deliverable Name** | **Deliverable Due Date** | **Submit To** |
| Monthly CER and Monthly Activity Report (MAR) | Fifteen (15) days after month of service/claim | Program Manager |
| Client level data entry into an HRSA approved data system | Fifteen (15) days after activity | Program Manager via CAREWare or other HRSA approved system |
| Ryan White Services Report (RSR) | Between January and March each year for prior Calendar Year data (due date defined by HRSA) | HRSA through Electronic Handbook |
| Quarterly Narrative Report | July 15, Oct 15, Jan 15, April 15 | Program Manager |
| Annual Service Delivery Plan | April 30 of each year | Program Manager |
| Quality Management Plan | May 1 of each year | Program Manager |
| Budget Projections | Dec 15 of each year for remainder of current year | Program Manager |
| Yearly Budget Worksheet and Narrative/justification | December 1 of each year for March 31 year end | Program Manager |