Ryan White Part B Program
Standards of Care

CT Department of Public Health
Infectious Diseases Division
TB, HIV, STD & Viral Hepatitis Programs
Health Care and Support Services Unit

Connecticut Department of Public Health

Accredited Health Department · Public Health Accreditation Board · PHAB

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Introduction

This document outlines the Connecticut Ryan White Part B Service Standards of Care for all services funded. The purpose of these standards is to ensure the quality and consistency of funded Ryan White core medical and support services categories throughout the State. These Standards were developed in collaboration with Ryan White Part B service providers. All comments were thoroughly reviewed and approved by the Ryan White Part B staff.

Section I of the Service Standards of Care applies to all funded programs and is known as the **Universal Service Standards of CARE.** Each section begins with the specific group standard and is followed by specific standards and measures. The standards of care in Section II apply to all programs funded by the Ryan White Part B Program for any of the HIV/AIDS services listed below.

- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Medical Case Management
- Medical Transportation
- Non-Medical Case Management (Transitional Case Management)
- Oral Health
- Outpatient/Ambulatory Health Services

In reviewing the items within this document, it is important to keep the following in mind:

- In addition to being adherent to these Service Standards of Care, it is also important to adhere to the HRSA/HAB National Monitoring Standards, Universal and HRSA/HAB National Standards – Part B.

- Items in the Universal Service Standards apply to all service categories.

- Throughout the document, the term client refers to individuals being served by the Ryan White Part B program.

- This is a living document and may change based on HRSA/HAB requirements, the needs of PLWH in Connecticut, and the services offered by providers. The Connecticut Ryan White Part B program will actively work to keep this document updated.

Ryan White Part B
Universal Service Standards of Care

The Universal Service Standards listed below are applicable to all service categories funded under the Ryan White Part B program. These standards are compliant with the HRSA/HAB monitoring standards issued April 2013. Recipients are required by HRSA/HAB to adhere to these monitoring standards and as such, sub-recipients funded for Ryan White Part B services will be held to the same standards.

Standard	Measure
Access to Care	
1. Services must be provided irrespective of age, physical or mental challenges, creed, criminal history, history of substance abuse, immigration status, marital status, national origin, race, sexual orientation, gender identity and expression, socioeconomic status, or current/past health conditions.	1. Policies and procedures and client grievances
2. Services must be provided in accordance with the American with Disability Act Guidelines Americans with Disabilities Act | U.S. Department of Labor (dol.gov). For information, refer to: ADA Guidelines.	2. Policies and procedures
3. Sub-recipient must have written instructions for clients on how to access the sub-recipients after business hours.	3. Policies and procedures and informational flyers and handouts
Continuity of Care	
1. Sub-recipient must establish formal collaborative agreements with HIV and other service organizations.	1. Memoranda of Understanding (MOU)
2. Sub-recipient must inform clients of the various HIV services and resources available throughout the state.	2. Informational flyers, handouts, resource manuals, literature. Documentation in client's records of resource given
3. Sub-recipients must have a resource referral and tracking system with identified HIV and other service sub-recipients.	3. Referral tracking system for each service category.
Staff Requirements	
1. Sub-recipient must have written personnel policies and procedures.	1. Policies and procedures
2. Sub-recipient must offer staff and contracted service sub-recipient job descriptions that address minimum qualifications, core competencies, and job responsibilities.	2. Position descriptions
3. Sub-recipient must ensure that services are provided in a culturally competent, compassionate, non-judgmental, and comprehensible manner.	3. Training/in-service certificates/sign-in sheets, staff interview, client satisfaction survey and client grievances.
4. Sub-recipient must ensure that staff and contracted service sub-recipients delivering	4. Documentation of knowledge via formal education, trainings, or other methods. Types

direct services to clients must have knowledge of the following: • HIV/AIDS • Effects of HIV/AIDS-related illnesses and comorbidities of clients • Psychosocial effects of HIV/AIDS on clients and their families/significant others • Current strategies for the management of HIV/AIDS • HIV-related resources and services in CT *For more information, refer to: DHHS Guidelines* Guidelines for the Use of Antiretroviral Agents in Adults and Adolescent Living with HIV 5. Sub-recipient must ensure that professional staff and contracted service sub-recipients follow, at minimum established codes of conduct for their discipline. 6. Sub-recipient must ensure that staff and contracted service sub-recipients receive ongoing supervision that is relevant and appropriate to their professional needs. 7. Sub-recipient must ensure that contracted service providers conduct business in a manner that ensures the confidentiality of clients and follows established protocols outlined in the Health Insurance Portability and Accountability Act (HIPAA) Health Insurance Portability and Accountability Act of 1996 (HIPAA) | CDC and the CT Public Health Code CT Public Health Code CT Public Health Code View Public Health Code (ct.gov) • Sub-recipient ensures Business Associate Agreement (BAA) executed with contracted service providers. 8. Sub-recipient medical case managers shall maintain a client case load of a minimum of 35 and maximum of 50 active clients at all times based on 35-to-40-hour work week.	of documentation may include, but is not limited to medical degree, license/certification, training certificate, transcripts, staff interview. 5. Codes of conduct, trainings/in-service certificates/sign-in sheets, staff interviews. 6. Supervisory/case conference meeting logs, documentation of supervisory client record reviews. 7. Policies and procedures, trainings/in-service certificates/sign-in sheets, staff signatures on sub-recipients confidentiality/HIPAA statements, staff interview • Executed copy of Business Associate Agreements with sub-contractors available on site. 8. Accurate documentation of individual client counts and services in e2CT data system.
Safety and Emergency Procedures	
1. Sub-recipient must ensure that services are provided in facilities that are clean, comfortable, and free from hazards. 2. Sub-recipient must have policies and procedures for the following: • Physical Plant Safety • Emergency Procedures that include fire, severe weather, and intruder/weapon threat • Medical/Health Care Crisis	1. Site visit observation. 2. Policies and procedures, site visit observation, training certificates and/or sign-in sheets, staff interview.

• Infection Control and Transmission Risk • Crisis Management • Risk Assessment • Accident/Incident Reporting **Note:** Sub-recipient must ensure that staff and contracted service sub-recipients are trained and follow the safety and emergency procedures.	
Eligibility Determination/Screening	
1. Sub-recipient must ensure that Ryan White funds are used as payer of last resort.	1. Policies and procedures, documentation of efforts of other resources not available at time of request(s) in client records of accessing other funding assistance.
2. Sub-recipient must verify proof of HIV status, residency, and ensure income is below 400% of the Federal Poverty Level (FPL).	2. Policies and procedures, documentation in client records of established HIV status within specified timeframe.
3. Proof of HIV status must be established within 10 business days of intake.	3. Policies and procedures, documentation in client records of benefits counseling/enrollment.
4. If a client is not enrolled in an insurance plan, sub-recipient must assist the client with benefits counseling and enrollment into an appropriate insurance plan.	4. Policies and procedures, documentation in client records of benefits counseling/enrollment.
5. Sub-recipient must ensure on an annual basis a sliding fee scale for services will be assessed and applied to clients with incomes greater than 100% of the Federal Poverty Level (FPL) that are based on a discounted fee of the client's annual gross income and family size (not family gross income), with exception of clients with gross incomes of less than 100% FPL which will not be charged. Clients unable to pay are required to sign and date the required "Zero Income Affidavit". Clients will no longer be charged for services when they reach their yearly financial cap.	5. Policies and procedures, financial documentation in client records.
6. Sub-recipient ensures eligibility policies that do not deem a veteran living with HIV ineligible for Ryan White services due to eligibility for Department of Veterans Affairs (VA) health care benefits.	6. Policies and procedures
Intake	
1. Sub-recipient must ensure clients are contacted within two (2) business days and complete an initial intake within ten (10) business days of contact with client.	1. Documentation in client records of timely intake with specified timeframes.
2. Sub-recipient must screen and refer clients into appropriate Ryan White service categories as determined by presenting needs.	2. Documentation in client records of screening and referrals for appropriate Ryan White and/or other services.
Confidentiality Related Documentation	

1. Sub-recipient must have a signed client informed consent for provision of Ryan White Part B Services and Release of Information to other RWB providers. This release will include at minimum: to whom the information will be released, the information being released, printed name and signature of client/legal guardian. Time limit of this Consent /Release of Information must not exceed 24 months.	1. Documentation in Client Record of signed RWB Consent / Release of Information Form.
2. Sub-recipient must have release of information form for all other service providers outside of Ryan White Part B. This release will include at minimum: to whom the information will be released, the information being released, printed name and signature of client/legal guardian.	2. Release of information form, documentation in client records of signed and dated releases of information including data.
3. Sub-recipient must have policy and procedures outlining client rights and responsibilities that, at minimum, includes: • Nature of services offered • The ability to terminate service at any time • Transfer and discharge procedures • Access to client records • Client progress notes	3. Documentation of signed and dated Clients Rights and Responsibilities.
4. Sub-recipients must have policy and procedures that outlines client responsibilities, at minimum, includes: • Scheduling, rescheduling, and canceling appointments • Drug and alcohol use on premises • Weapons on premises • Acts of abuse towards staff, property or services	4. Documentation of signed and dated Clients Rights and Responsibilities.
5. Sub-recipient must have an objective process to address and track clients' grievances.	5. Policies and procedures, documentation of signed and dated grievance policy, and resolution of grievance.
6. Sub-recipient must have policies and procedures to ensure that clients' medical records and other personal health information are: • Securely faxed, emailed or phoned • Safely transported during the courses of conducting business • Securely stored electronically with limited access • Shared with third parties in accordance with HIPAA	6. Policies and procedures, staff interview, site visit observation.

• Sub-recipients must ensure that client's records are maintained in a secure location. **Note:** Sub-recipient must assure that when a client or the client's legal guardian signs a Consent / Release to obtain and disclose information, the client / legal guardian understands that information from the client's record will be shared and with whom and for what purpose.	
Client Satisfaction	
1. Sub-recipient must establish evaluation methods to assess client satisfaction and receive feedback on services using any of the following methods: • Client satisfaction survey • Suggestion box or other client input mechanism • Focus groups and/or public meetings 2. Sub-recipient must use results from evaluation methods to improve service delivery.	1. Client satisfaction survey/results, visual verification of suggestion box or other client input mechanisms during site visit, notes or reports from focus groups and/or public meetings. 2. Quality Improvement Plan, modification to service delivery policies and procedures based on feedback, inclusion of client feedback in internal training/staff communications.
Discharge/ Transfer	
1. A discharge or transfer from Ryan White services must occur if any of the following criteria happens: • Completion of services • Determined to be ineligible • The client/legal guardian has requested the case be closed • Relocation of client outside of the sub-recipients State of CT or geographic service area • Inability to contact the client for more than six months • The client's needs are more appropriately addressed through other sub-recipients • The client exhibits acts of abuse towards staff, property or services • Client's death	1. Documentation in records of client being discharged or transferred to another HIV program or are deceased. • Documentation of "Case Closed" service with reason for discharge entered in e2CT. • Documentation of discharge with MCM and supervisor signature and date • Documentation clients lost to care were referred to Disease Infection Specialist (DIS).
Reporting	
1. Sub-recipient must submit program narrative, statistical data, and expenditure reports as outlined in Department of Public Health Terms and Conditions of State Contract.	1. Records that contain and adequately identify the source of information pertaining to: • Federal award, expenses, obligations, unobligated balances, program income generated from 340B, sliding fee scale and billable services.

	• Aggregate client data on services provided; clients served, client demographics and client service reimbursements.
Monitoring	
1. Sub-recipient will be monitored for fiscal, programmatic and 340B (if applicable) compliance as required by the HRSA HIV/AIDS Bureau's National Monitoring Standards.	1. Documentation of allowable costs, policies and procedures that include administrative and fiscal requirements
2. Sub-recipients will receive annual comprehensive site visit and/or during a public health emergency situation (e.g. pandemic or natural disaster) tele-monitoring meetings will occur monthly, bi-monthly, quarterly and/or needed.	2. Review policies and procedures, chart reviews, interaction with clients and staff, progress on meeting corrective action plan goals, and provided technical assistance.
3. Sub-recipient will receive annual fiscal monitoring site visit.	3. Review policy and procedures, chart of accounts, Time and Effort, general ledger, progress on meeting corrective action plan goals, and provided technical assistance.
4. Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of $203,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards of sub-recipients for substantive work under a HRSA grant or cooperative agreement.	4. Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Salary Limit. Determine whether individual staff receives additional HRSA income through other sub-awards of sub-recipients.
5. Salary Limit Fringe Benefits: If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	5. Identification of individual employee fringe benefit allocation.
6. Corrective action will be taken if sub-recipient fails to meet program and/or fiscal compliance.	6. Review corrective action plan including resolution of issues identified in the plan

Connecticut Ryan White Part B Program
Emergency Financial Assistance (EFA)

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Emergency Financial Assistance provides limited one-time or short-term payments to assist an HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.
Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

HRSA Program Monitoring Standard:
Support for **Emergency Financial Assistance (EFA)** for essential services including utilities, housing, and food (including groceries, food vouchers, and food stamps), or medications, provided to clients with limited frequency and for limited periods of time, through either:

- Short-term payments to agencies
- Establishment of voucher programs

Note: Direct cash payments to clients are not permitted

HCSS Ryan White Part B Service Standard:

Standard	Measure
Service Description	
1. Sub-recipient must have established criteria for the provision of Emergency Financial Assistance (EFA) that includes, at minimum: • Income limits • Amount limits • Requirements to access other resources before Ryan White funds • Documentation of need and why it is an emergency • Documentation verifying that client is in HIV medical care • Established cap for housing, and/or utilities (electric, heating oil, gas, phone).	1. Documentation in client records of client meeting eligibility criteria. Policies and procedures including documentation of agency cap in client records of emergency financial assistance.

Service Delivery	
1. Sub-recipient must have established policies and procedures for service delivery and established examples of client hardship to provide the following: • Utilities (electric, heating oil, gas, phone) • Housing (arrearage, first month rental assistance) • Medications (not available on CADAP Formulary) 2. **Unallowable services include**: • Food • Eye glasses prescription • Medical transportation • Mortgage payments 3. **No direct cash payment(s) to clients permitted**	1. Policies and procedures. Copy of shut off notice or documentation of past due bills.
Continuum of Care	
1. Sub-recipient must ensure that clients are in care or actively taking steps to engage in HIV medical care. If clients need assistance accessing HIV medical care, referrals must be provided.	1. Documentation in client records of being in HIV medical care.

Service Unit(s) definitions:
Housing, medications, and utilities (electric, heating oil, gas, phone)

E2CT Data Reporting:
Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.

Connecticut Ryan White Part B Program
Food Bank/Home-Delivered Meals

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the HRSA RWHAP.

HRSA Program Monitoring Standard:
Funding for **Food Bank/Home-delivered Meals** that may include:

- The provision of actual food items
- Provision of hot meals
- A voucher program to purchase food

May also include the provision of non-food items that are limited to:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems communities where issues with water purity exist

Appropriate licensure/certification for food banks and home delivered meals where required under State or local regulations.

No funds used for:

- Permanent water filtration systems for water entering the house
- Household appliances
- Pet food

Other non-essential products

HCSS Ryan White Part B Service Standard:

Standard	Measure
Service Description	
1. Sub-recipient must have established criteria for the provision of food vouchers to include: • Voucher program to purchase actual food item(s)	1. Documentation in client records of client's eligibility criteria.

Service Delivery	
1. Sub-recipient must have established policies and procedures for service delivery for clients that include: • Improving nutritional status • Maintaining weight 2. **Unallowable services include:** • Food Pantry • Home delivered meals for homebound clients • Personal hygiene products • Household cleaning supplies • Water filtration/purification systems in communities where issues of water safety exist	1. Policies and procedures with documentation of identified areas. Documentation of adherence to agency cap on service delivery in client record.

Service Unit(s) definition:
Food voucher(s)

E2CT Data Reporting:
Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.

Connecticut Ryan White Part B Program
Medical Case Management Services

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum.

Activities provided under this service category may be provided by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented activities above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Activities provided under the Medical Case Management service category have as their objective improving health care outcomes whereas those provided under the Non-Medical Case Management service category have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

HRSA Program Monitoring Standard:
Support for **Medical Case Management** (including treatment adherence) to 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 staff who are part of the

clinical care team, through all types of encounters including face-to-face, phone contact, telehealth and any other form of communication.
Activities that include at least the following:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan at least every 6 months, as necessary

Service components that may include:

- A range of client-centered services that link clients with health care, psychosocial, and other services, including benefits/entitlement counseling and referral activities assisting them to access other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical, Manufacturers' Patient Assistance Programs, other State of local health care and supportive services)
- Coordination and follow up of medical treatments
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments
- Client –specific advocacy and/or review of utilization of services
- **Performance Measures:**
- Refer to Summary of Clinical Performance Measures Part B

HCSS Ryan White Part B Service Standard:

Standard	Measure
Staff Requirements	
1. The minimum education requirement for medical case managers is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. Medical case managers who were hired prior to 2015 may substitute related direct client service experience under the supervision of a human services professional for a period of 2 years of full time work regardless of academic preparation.	1. Copy of diploma/credentials If medical case manager is hired prior to 2015 and does not meet the minimum education requirements, documentation of 2 years of related direct client service experience under supervision.
2. The minimum requirements for medical case management supervisors is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university. Medical case management supervisors who were hired prior to 2015 (grandfather in) may substitute related direct client service experience under the supervision of a human	2. Copy of most recent license/credentials If medical case management supervisor is hired prior to 2015 and does not meet the minimum education requirements,

services professional for a period of 5 years of full time work regardless of academic preparation. 3. Medical case managers must have completed the training for medical case management, including annual participation of HIV prevention and care related trainings. 4. Direct supervisors of medical case managers must identify, and document participation of trainings for medical case managers, including annual participation of HIV prevention and care related trainings. **Note:** Monolingual sub-recipients must have at least one (1) Full Time Employee (FTE) MCM on staff.	documentation of 5 years of related direct client service experience under supervision. 3. Training certificates/documentation 4. Training certificates/documentation
ASSESSMENT	
1. A face-to-face and/or tele-health assessment with a client must be made within ten (10) business days and the initial intake must be completed. All clients who request or are referred for HIV MCM services will be contacted within 2 business days after a referral has been received. 2. The medical case manager must provide ongoing education to clients on identified treatment adherence needs. At minimum, the medical case manager must address: • HIV 101 (including CD4 and viral load) • Insurance and health system navigation • Medical care and treatment adherence (including readiness to HIV medications) **Note:** Circumstances that necessitate a deviation from this time frame must be documented in client progress notes.	1. Documentation in client record of completed assessment form, and signed and dated progress notes within specified timeframe 2. Documentation in client chart of education and referral to any provision of specialty HIV care
Care Plan	
1. Medical case managers in collaboration with their client develop and implement client care plan within 10 business days. 2. The care plan must include: • A description of the need(s) • Action steps to resolve the need(s) • Timeframes to resolve the need(s) • Documentation of who will complete action steps • Dated signatures of the client and medical case manager	1. Documentation in client records of completed care plan within specified timeframes 2. Completed and signed care plans

Care Plan Monitoring	
1. The medical case manager must maintain ongoing contact and follow-up with clients based on acuity level and care plan needs. 2. Medical case manager must address clients' barriers to access necessary resources and achieving care plan goals on an ongoing basis. 3. Medical case manager must maintain regular contact and follow-up with clients' medical providers and other core or support referred services. 4. Medical case manager must review and update the care plan on an as needed basis. At minimum, a new, updated care plan must be completed or reassessed every 6 months.	1. Documentation in client record of care plan monitoring 2. Documentation in client records of ongoing contact with medical providers and other referred service providers 3. Documentation in client care plans that needs identified are addressed 4. Documentation in client records of a new care plan after each reassessment
Reassessment	
1. Medical case manager must complete a reassessment every six months.	1. Documentation in client record of a reassessment at specified timeframes
Documentation	
1. Medical case manager must document any and all efforts to work with client and provide services, such that progress notes and units of services match in database.	1. Documentation in client charts of progress notes that correspond to the units of service
Discharge/Transfer	
1. Medical case manager must consult with supervisor to decide when a client is to be discharged. 2. After a decision has been made to discharge client, the medical case manager must complete a discharge summary within 10 business days. 3. Medical case manager must ensure a discharge summary that includes: • Reason for discharge • Client-centered discharge plan • Referrals provided • Dated and signature of the medical case manager • "Case Closed" service entered in e2CT 4. Medical case management supervisor must review and sign the discharge summary.	1. Documentation in client charts of discharge summary within specified timeframes 2. Documentation in client records of discharge summary within specified timeframes 3. Completed and signed Discharge Summary form including documentation of "Case Closed" service entered in e2CT 4. Documentation in client charts of discharge plan with relevant signatures and dates

Service Unit(s) definitions:

Face to face encounter, virtual (e.g. Teams, Zoom) consultation, phone consultation, initial care plan development, care plan updates, coordination of services, and referrals

E2CT Data Reporting:

Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes

Connecticut Ryan White Part B Program
Medical Transportation

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Costs for transportation for medical providers to provide care should be categorized under the service category for the service being provided.

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees.

HRSA Program Monitoring Standard:
Funding for **Medical Transportation Services** that enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, through either direct transportation services or vouchers or tokens.

May be provided through:

- Contracts with providers of transportation services
- Voucher or token systems
- Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Purchase or lease of organizational vehicles for client transportation programs, provided the grantee receives prior approval for the purchase of a vehicle

HCSS Ryan White Part B Service Standard:

Standard	Measure
Eligibility Criteria	
1. Sub-recipient must screen for medical transportation eligibility by assessing level of need and determining if client has other means of transportation. Based on screening, a determination of what type of medical transportation is appropriate (e.g. bus pass, cab, Uber and Lyft services). • Bus pass, cab, Uber, Lyft services must be used by client to access HIV-related health and support services, which includes getting to and from appointments. • Sub-recipient must make appropriate referrals to other transportation resources if clients do not meet the criteria for medical transportation.	1. Policies and procedures and documentation in client charts of screening for appropriate means of transportation • Documentation in client charts that the provision of bus pass, cab, Uber, and Lyft services has met established criteria • Documentation in client records of referrals
Service Delivery (for direct transportation services)	
1. Sub-recipient must ensure that a proper job description, resume, and valid State license is provided (if applicable). 2. Sub-recipient has established agreements with transportation service operators including: • Licensing • Registration • Insurance • Insurance and safety requirements • Necessary action to be taken in the event of an accident • Use of safety belts • Cell phone usage • Vehicle maintenance • Disability/handicap door to door service 3. Sub-recipient has established agreements with livery transportation services for cab, Uber and Lyft services.	1. Policies and procedures 2. Documentation in sub-recipients administrative files 3. Documentation in sub-recipient administrative files

Service Unit(s) Definition:
Bus pass, cab, Uber, and Lyft services, and gas cards

E2CT Data Reporting:
Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes

Connecticut Ryan White Part B Program
Non-Medical Case Management (Transitional Case Management Services)

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Non-Medical Case Management Services (NMCM) is the provision of a range of client-centered activities focused on improving access to and retention in needed core medical and support services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Program Guidance:
NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

HRSA Program Monitoring Standard:
Support for **Case Management (Non-medical)** services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services
May include:

- Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may be eligible
- All types of case management encounters and communications (face-to-face, telephone contact, other)
- Non-Medical Case Management (Transitional case management) for incarcerated persons as they prepare to exit the correctional system

Note: Does not involve coordination and follow up of medical treatments

HCSS Ryan White Part B Service Standard:

Standard	Measure
Staff Requirements	
1. The minimum education requirement for transitional case managers is a high school diploma or GED.	1. Copy of diploma/credentials
2. The minimum education requirements for transitional case management supervisors is a Registered Nurse (RN), Bachelor of Social Work (BSW), or other related health or human service degree from an accredited college or university.	2. Copy of diploma/credentials
3. Non-Medical Case Mangers (Transitional case managers) must have completed the training for medical case management, including annual participation of HIV prevention and care related trainings.	3. Training certificates/documentation
4. Direct supervisors of transitional case managers must have completed the training for medical case management and annual participation of HIV prevention and care related trainings.	4. Training certificates/documentation
Assessment of Needs	
1. Initial problems or needs are identified and prioritized by the client and the transitional case manager.	1. Documentation in client charts of the assessment of needs
Care Coordination Plan and Follow-up	
1. Developed care coordination plan that addresses the identified need(s) and provides referrals/resources collaboratively with the client.	1. Documentation in client charts of completed care coordination plan
2. Transitional case manager must address any barriers clients have accessing necessary resources (e.g. housing, medical care, medications.)	2. Documentation in client chart of identifying and addressing barriers
3. The Non-medical case manager must conduct follow-up to referrals/resources within 10 business days of creating the care coordination plan.	3. Documentation in client charts of following-up on referrals/resources within specified timeframe
Discharge/Transfer	
1. Non-Medical case manager must coordinate with medical case manager.	1. Documentation of transition plan dated and signed by non-medical case manager and medical case manager
2. After a decision has been made to discharge client, the non-medical case manager must complete a discharge summary within 10 business days.	2. Documentation in client records of discharge summary within specified timeframes
3. Non-Medical case manager must ensure a discharge summary that includes: • Reason for discharge	3. Completed and signed Discharge Summary form

• Client-centered discharge plan • Referrals provided • Dated and signature of the medical case manager • Documentation of "Case Closed" service entered into e2CT. 4. Non-Medical case management supervisor must review and sign the discharge summary.	• Include documentation of "Case Closed" service entered in e2CT 4. Documentation in client charts of discharge plan with relevant signatures and dates

Service Unit(s) definitions:

Face to face encounters, linkage to medical care, medical case management and referrals to appropriate support services.

E2CT Data Reporting:

Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.

Connecticut Ryan White Part B Program
Oral Health Care Standard of Care

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Oral Health Care activities include diagnostics, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

Program Guidance: None at this time.

HRSA Program Monitoring Standard:
Support for **Oral Health Services** including diagnostic, preventive, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral health treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals.

HCSS Ryan White Part B Service Standard:

Standard	Measure
Staff Requirements	
1. Sub-recipient must ensure contracted staff have current dental health care professional license and meet dental health requirements based on State and local laws to provide such services.	1. Copy of most recent license
Treatment Plan	
1. Sub-recipient staff charts will have treatment plan completed signed and dated by client in the measurement year.	1. Documentation in client chart of completed treatment plan within specified timeframe and completed signed, and dated treatment plan
Continuity of Care	
1. Sub-recipient staff charts will have documentation that client's oral health care services fall within specified service caps, expressed by dollar amount, and type of procedure.	1. Documentation in client charts of services delivered, amount, and number of procedures

Service Unit(s) Definition:
Oral evaluation, treatment plan

E2CT Data Reporting:
Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.

Connecticut Ryan White Part B Program
Outpatient/Ambulatory Health Services

Important: Prior to reading service-specific standards, please read the HRSA/HAB National Monitoring Standards—Universal, HRSA/HAB National Monitoring Standards—Part B, and the Universal Standards outlined in this document.

HRSA Service Description:
Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

Program Guidance:
Treatment adherence activities provided during an Outpatient/Ambulatory Health Service visit are considered Outpatient/Ambulatory Health Services, whereas treatment adherence activities provided during a Medical Case Management visit are considered Medical Case Management services.
Non-HIV related visits to urgent care facilities are not allowable costs within the Outpatient/Ambulatory Health Services Category.
Emergency room visits are not allowable costs within the Outpatient/Ambulatory Health Services Category.

See PCN 13-04: Clarifications Regarding Clients Eligible for Private Insurance and Coverage of Services by Ryan White HIV/AIDS Program

See also Early Intervention Services

HRSA Program Monitoring Standard:
Provision of **Outpatient and Ambulatory Medical Care** defined as the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting (not a hospital, hospital emergency room, or any other type of inpatient treatment center), consistent with Public Health Service (PHS) guidelines and including access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Allowable services include:

- 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 of medication therapy
- Education and counseling on health issues
- Well-baby care
- Continuing care and management of chronic conditions
- Referral to and provision of HIV-related specialty care (includes all medical subspecialties even ophthalmic and optometric services)

As part of Outpatient and Ambulatory Medical Care, provision of **laboratory tests** integral to the treatment of HIV infection and related complications.

HCSS Ryan White Part B Service Standard:

Standard	Measure
Staff Requirements	
1. Primary health care clinics must be licensed and, where applicable, accredited to deliver primary medical care. 2. Ryan White clinic staff and contracted service sub-recipient must have current license and/or certification and practice within their professional scope of practice as required by the State of Connecticut.	1. Copy of most recent license and accreditation 2. Copy of most recent license
Continuity of Care	
1. Clinical performance measures HIV primary care must include: • Viral Load Suppression • Hepatitis B and C screenings performed at least once since diagnosis • Hepatitis B vaccination series completed as recommended by medical provider • PCP Prophylaxis: CD4 count below 200 cells/mm3 who were prescribed prophylaxis • Prescribed ART within the previous year • Pregnant women with HIV who were prescribed antiretroviral therapy • Syphilis test performed within the previous year • TB testing performed at least once since diagnosis • Mental Health and Substance abuse screening within the previous year	1. Documentation in client chart and database of specified clinical performance measures

• HIV Risk Reduction Counseling during the previous year • Care plan updated every six months in the measurement year 2. Sub-recipient must work in partnership with their client to offer adequate information about their health and client-centered treatment options.	2. Documentation in client records of instructions and education regarding treatment options.

Service Unit(s) definition:

Face to face medical visit, telehealth visit, diagnostic testing and laboratory testing

E2CT Data Reporting:

Part B service providers are responsible for documenting and keeping accurate records of Ryan White Program Data/Client information, units of service, and client health outcomes.