

RIDER E
PROGRAM REQUIREMENTS
(Maine Center for Disease Control and Prevention)

The following provisions specify requirements for Maine Center for Disease Control and Prevention Services and apply to all agreements with the Department.

- A. Interpretation Services (Communication Access).** The Provider shall determine the primary language of individuals requesting services and ensure that the services are provided either by a bi-lingual clinician or with the assistance of a qualified interpreter when English is not the primary language. The client shall not be charged for this service.
- B. Accessibility for the Deaf and Hard of Hearing.** The Provider shall maintain and periodically test appropriate telecommunication equipment including TTY, videophone, or amplified telephone. Equipment must be available and accessible for use by clients and staff for incoming and outgoing calls. The Provider shall ensure that appropriate staff has been trained in the use of the telecommunications device and that the TTY telephone number is published on all of the Provider's stationery, letterhead, business cards, etc., in the local telephone books, as well as in the statewide TTY directory. The Provider, at its expense, shall obtain the services of a qualified sign language interpreter or other adaptive service or device when requested by a consumer or family member. Interpreters must be licensed with the Maine Department of Professional and Financial Regulation in the Office of Licensing and Registration. The Provider shall document the interpreter's name and license number in the file notes for each interpreted contact.
- C. Deaf and/or Severely Hard of Hearing.** Providers who serve deaf and/or severely hard of hearing consumers shall:
1. Provide visible or tactile alarms for safety and privacy (e.g., fire alarms, doorbell, door knock light);
 2. Provide or obtain from the Maine Center on Deafness loan program a TTY or fax as appropriate for the consumers' linguistic ability and preference and a similar device for the program office; and
 3. Train staff in use and maintenance of all adaptive equipment in use in the program, including but not limited to hearing aids, assistive listening devices, TTY, fax machine, television caption controls, and alarms.

The Maine Center on Deafness www.mainecenterondeafness.org offers assistance to individuals who need specialized telecommunications devices.

- D. Provider Responsibilities: Deaf, Hard of Hearing and/or Nonverbal.** Providers who serve deaf, hard of hearing, and/or nonverbal consumers for whom sign language has been determined as a viable means of communication shall:

1. Provide ongoing training in sign language and visual gestural communication to all staff on all shifts who need to communicate meaningfully with these clients, and shall document staff attendance and performance goals with respect to such training;
2. Develop clear written communication policies for the agency and each program of the agency, including staff sign/visual gestural proficiency expectations and when and how to provide qualified sign language interpretation; and
3. Ensure that staff has a level of proficiency in sign language that is sufficient to communicate meaningfully with consumers.

The following requirements are applicable to the provision of HIV Medical Case Management services under this agreement:

- E. Applicable Standards.** The Provider shall comply with all standards applicable to the HIV medical case management service, including:
1. Title XXVI of the Public Health Service Act (Ryan White HIV/AIDS Program);
 2. *HIV/AIDS Case Management Program Standards* to be incorporated in 10-144 of the Code of Maine Regulations;
 3. *MaineCare Benefits Manual, 10-144 CMR Chapter 101*; Chapter II, Section 13;
 4. *The CAREWare Guidance Manual* issued by Maine CDC, including any updates thereto; and
 5. *Ryan White HIV/AIDS Program Part B Monitoring Standards*, including Fiscal Monitoring Standards, Program Monitoring Standards, and Universal Monitoring Standards.
- F. Client Eligibility.** The Provider acknowledges the following determine a person's eligibility for HIV medical case management services under this agreement:
1. Verified and documented diagnosis of HIV infection
 2. Verified and documented legal household income of 500% of the Federal Poverty Level or below
 3. Verified and documented insurance coverage
 4. Verified residence within the State of Maine

Verification of HIV infection must include the client's full, legal name and may be documented in medical records, confidential detectable viral load results, confidential HIV antibody test results, or a statement from the client's medical provider verifying the client's HIV status.

HIV verification must be received within 30 days of the client's initial referral/request for service.

Household income must be verified every six months during the Semi-Annual Certification process. "Household" is defined as the client and any legal household members (legally married spouse, dependent children, dependent adults). Income for all members of the household must be verified. Verifying documents must be

dated within one year.

Any client whose household income exceeds 500% of the Federal Poverty Level must be discharged due to ineligibility for services.

Residence and insurance coverage are verified and documented every six months during the Semi-Annual Certification process.

- G. Case Load Management and Wait List.** The average caseload for full-time case managers is 35-50 active clients. When the average caseload for case managers exceeds 35-50 cases and case managers feel that additional cases will compromise services, the Provider may consider starting a waiting list.

The Provider will contact the Ryan White Part B Program Coordinator when a waiting list is being considered.

If a waiting list is initiated, the Provider monitors and manages the list through a triage system in consultation with the Ryan White Part B Program Coordinator.

- H. Mandated Reporting.** In addition to the provisions in Rider D, 2, Reporting Suspected Abuse and Neglect: The Provider shall develop and implement written policies and procedures to comply with:

1. Maine CDC's policy for HIV Transmission Prevention;
2. State law related to reporting suspected incidents of abuse or neglect;
3. State law related to clients who pose a danger to themselves or others;
4. Known or suspected unethical behavior.

The Provider will train all staff involved with case management clients on these. All case managers will be trained regarding professional ethical standards and principles. The Provider keeps a record of trainings.

- I. Availability and Access to Case Management Services.** The Provider will maintain regularly scheduled hours of operation.

When a case manager is unavailable (i.e. at trainings, on vacation, out sick), clients will be informed of this upon calling, either by voicemail or by another staff member. Clients will also be informed of when the case manager will become available. If the case manager will not be available within one working day, another case manager will be made available to assist clients.

Client phone calls will be returned within one working day. The case manager will document all phone calls and phone call attempts to the client and on the client's behalf.

Appointments will be scheduled with clients within 5 working days of a requested appointment unless the client prefers to schedule for a later date.

During the intake/assessment process, the Provider provides clients with written

information about services available in the area for emergency situations. The Provider's phone answering machine refers clients to emergency resources in case of emergency.

For clients unable to access services during normal business hours because of work obligations, the Provider will make services available outside of normal business hours at least once a month (i.e. offering home visit, phone call or other type of contact during evening hours once per month).

- J. Clinical Records.** Agencies use all required standardized forms issued by the Ryan White Part B Program. Agencies are encouraged to use all standardized forms developed by the Ryan White Part B Program.

Client records are thorough, complete, organized, and clear from the viewpoint of an outside reviewer.

The Provider manages records according to its Confidentiality Policy to ensure that access to records is limited to Provider staff that must access records, and those persons that have legal authority to access records.

Any handwritten documentation is completed legibly in blue or black ink. Errors are corrected with a single line drawn through the incorrect text with the case manager's initials and date next to the line.

All documents are fully completed. Sections that are not completed contain a notation of "n/a" or a line drawn through the entire section. No sections of forms should be left blank.

If any information is added after a form is completed, the person making the amendment must initial and date each change.

Case notes must be entered in CAREWare for every contact with or on behalf of a client and must be entered within 15 days of the service. Incorrect data in CAREWare case notes is noted but not deleted. Case notes include the case manager's name and title.

Client records are maintained for 6 years following final client discharge. Providers maintain an inventory of records destroyed, including basic demographics of clients and dates of service initiation and termination.

- K. Record Reviews.** A random, unduplicated sample of client records will be reviewed quarterly by Provider staff and at least annually by the Ryan White Part B Program. At least 10% of client records, and a minimum of five client records, will be reviewed each quarter for a total of 40% of unduplicated client records reviewed annually.

Records should be reviewed by clinical or administrative supervisors; a staff person may not review his or her own client records. Findings from the client record review will be used for staff education and supervision, and program and organizational

planning.

All record reviews will be conducted using the Standard Client Record Review form. A record will be considered complete when “yes” or “N/A” is marked for each item in the record.

- L. Professional and Other Qualified Staff.** In addition to the provisions in Rider B, 11, Employment and Personnel: The Provider will have a job description for case managers that specifies the minimum qualifications upon hiring, in accordance with the HIV/AIDS Case Management Program Standards.

The Provider documents that newly hired case managers are trained and supervised to achieve the following core competencies within the first 6 months of employment and documents assessment of core competency achievement at least annually:

- Perform Case Management Practices as outlined in the current rules for HIV Case Management as well as Rider A of this contract.
- Apply ethical, professional judgment, relying on ethical standards and principles outlined by the case managers’ professional association.
- A knowledge of the National CDC definitions for HIV and AIDS; a working and up-to-date knowledge of the Public Health Services standards for HIV care; an understanding of common opportunistic infections and AIDS-defining illnesses; an understanding of common dual-diagnoses including Hepatitis A, B and C, substance abuse and mental health diagnoses; a basic understanding of routine lab tests and the implications of results (CD4 count, viral load); a basic understanding of HIV genotyping; and comfort discussing medical care in lay terms with clients and medical providers.
- An understanding of the major HIV drug classes and their mechanisms; a knowledge of common side-effects; a basic knowledge of adherence requirements for medication effectiveness; a basic understanding of common contraindicated over-the-counter products and nutritional supplements and comfort referring clients to physicians for more information; a knowledge of effective adherence tools and techniques; and skills and comfort discussing medications in lay terms with clients and medical providers.
- An advanced knowledge of HIV transmission via risk behaviors; an advanced knowledge of the principles, practices and techniques of risk reduction; a knowledge, skills and comfort discussing sex and sexuality; a knowledge, skills, and comfort discussing illicit drug use; a respect for and comfort with a diversity of lifestyles and personal choices, and a knowledge of key referral programs, including Partner Services (PS) and Comprehensive Risk Counseling Service (CRCS).
- A thorough understanding of public insurance programs and the ability to understand private insurance programs, including COBRA, employee and privately purchased policies, and related limitations (pre-existing conditions, cost caps, formulary restrictions).
- Negotiate complicated systems and difficult situations, using good clinical judgment.

- Prepare professional, proper documentation and reports related to case management services.
- Utilize CAREWare software to record, manage, and report client and service data as required in state CAREWare guidance.
- Ability to teach life skills management, such as budgeting, stress management, time management, and disclosure of HIV status to partners.
- Apply working knowledge of and referral resources, minimally in each of the core competency areas listed above, as well as:
- MaineCare/Medicaid programs, benefits and eligibility processes and criteria, with advanced knowledge of the 1115 Waiver Limited Benefit Program for People Living with HIV/AIDS.
- Medicare, particularly the Part D Prescription Drug Coverage and its enrollment processes, benefits structure, member requirements, formulary and appeals policies.
- AIDS Drug Assistance Program (ADAP) benefits and enrollment process.
- Social Security Programs, including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), and their benefits, application, eligibility, and appeals processes.
- Housing assistance programs, including HOPWA (Housing Opportunities for People with AIDS) and Section 8, their benefits, application, eligibility, waiting list, and appeals processes.
- Transportation programs, particularly as related to MaineCare member benefits and disability benefits.
- General Assistance programs and their benefits and eligibility processes
- Medical care, HIV specialty care, STD clinics/services, perinatal care, dental care, and client-friendly pharmacies.
- Substance abuse services.
- Mental health services.
- Sexual assault counseling/services; domestic violence services/assistance.
- Legal services.
- Food assistance.
- Vocational assistance.
- Social, educational, and advisory opportunities for People Living with HIV/AIDS.

M. Supervision. Supervision is provided in accordance with the HIV/AIDS Case Management Program Standards.

Supervisory time is not less than 4 hours per month per full-time staff member. Case managers who work less than 40 hours per week may receive an amount of supervision that is proportionate to their part-time commitment.

N. Grievances. The Provider's Grievance Policy, written in plain language, is approved by the Ryan White Program Coordinator and is offered to clients at each intake/assessment.

At a minimum, the following explanations, components and timeframe must be included in the Grievance Policy:

- A grievance is initiated by a client, and may address any complaint related to the services he/she has received at the case management Provider.
- As a first step, clients are encouraged to speak with their case manager and/or those staff members that are directly involved to resolve the issue. If the issue is not resolved within 5 working days, a formal grievance may be issued.
- A formal grievance must be recorded in writing, and a client shall be given assistance to write the grievance if he/she is unable to write it on his/her own. The Provider will provide 4 total hours of staff time over 2 weeks to assist a client with writing a grievance (meeting with the client, drafting the grievance, reviewing the draft with the client, making corrections).
- The written grievance will be submitted to the supervisor of case managers and/or Provider director who will attempt to achieve resolution with the parties involved. If the issue is not resolved, it may be referred for review at a higher level within the Provider. However, if the issue is not resolved at the Provider level – and/or is not resolved to the client’s satisfaction – within 30 days of filing a written grievance, the client may appeal to the Ryan White Part B Coordinator.
- The Provider will prepare a written summary for every formally registered grievance. The summary will include a statement of the specifics of the case, the procedure that was followed, the participants in the procedure, actions taken, all relevant dates, and the outcome of the process. The summary will be sent to the Ryan White Part B Program Coordinator within 2 weeks of completing the grievance process. The summary will also be retained by the Provider for at least 5 years.
- A client may appeal to the Ryan White Part B Coordinator to review a grievance by submitting her/his written grievance when no resolution, or satisfactory resolution, is arrived at within 30 days at the Provider level. The Part B Coordinator will review the grievance within 35 days of when the client appeals to the state, and will respond to the client in writing.
- A client may contact the Office for Civil Rights at the US Department of Health and Human Services to address privacy or confidentiality issues. The contact information for this office will be provided in the Grievance Policy as follows:

Region I, Office for Civil Rights
US Dept of Health & Human Services
Government Center, JFK Federal Building
Room 1875
Boston, MA 02203
617-565-1340

- O. Confidentiality.** In addition to the provisions in Rider D, 3, Confidentiality: The Provider will have written a Confidentiality Policy, a Confidentiality Statement, a Notice of Privacy Practices, and a Release of Information form that are compliant with all relevant federal and state laws, including but not limited to the Privacy rule

of the federal Health Insurance Portability and Accountability Act of 1996, Maine CDC's Privacy Policy, and the following state laws: 22 M.R.S.A. § 1711-C; 5 M.R.S.A. § 19203; 22 M.R.S.A. § 833; 22 M.R.S.A. § 3477, 4011-A & 4011-B. Each of these documents must be approved by the Ryan White Part B Program Coordinator.

The Confidentiality Policy will describe how client information will be used and disclosed, and include provisions for Authorized Access, Physical Security, Technological Security, and Transmission Security.

All staff and volunteers will be trained on the Confidentiality Policy at hire and annually thereafter and sign and date the Confidentiality Statement. Signed and dated Confidentiality Statements will be on file for all staff and volunteers.

All clients will receive a plain language Notice of Privacy Practices at intake and annual assessment.

P. Referrals. Providers must maintain appropriate referral relationships with entities that constitute key points of entry, including:

- Emergency rooms
- Substance abuse and mental health treatment programs
- Detoxification centers
- Detention facilities
- Clinics regarding sexually transmitted disease
- Homeless shelters
- HIV disease counseling and testing sites
- Health care points of entry specified by eligible areas
- Federally Qualified Health Centers
- Entities such as Ryan White Part C grantees

Providers are required to establish written referral relationships with specified points of entry. Additionally, providers must document referrals from these points of entry.

The following expectations are in place regarding timeliness and follow up of referrals:

Referral information should be organized in a central agency location, accessible to all case managers, and must be updated at least yearly.

Q. Administrative Costs. Agencies must expend no more than 10% of their Ryan White Part B funds on administrative costs. Per the Ryan White Legislation, administrative activities include:
Usual and recognized overhead, including established indirect rates for agencies;
Management oversight of specific programs funded under this title; and
Other types of program support, such as quality assurance, quality control, and related activities.

- R. Satisfaction Surveys.** The Department will prepare and package standardized annual client satisfaction surveys. The Provider will assist in distributing surveys to all Provider clients. The Department will receive survey results from clients and will provide the Provider with aggregate survey results.

Findings will be used to identify and resolve problems, evaluate current practices and services, make needed changes, and plan for unmet needs. Overall rate of client satisfaction will be no more than 2% less than previous year.

- S. Site Reviews.** Department staff will site visits at least annually to review programmatic and financial issues. Site visits will be scheduled in collaboration with the Provider. The Provider will receive Site Visit criteria in advance of the visit, and will be required to provide materials in advance of the visit.

The Part B Program will issue a site review report to the Provider director within 30 days of the on-site visit. Provider directors may respond in writing to the site review report within 30 days of issuance from the Part B Program.

- T. Data Collection and Reporting.** Providers utilize the Ryan White CAREWare database for data collection.

All users shall receive thorough training prior to using CAREWare. Only those staff or volunteers who have completed confidentiality training with the Provider and signed a confidentiality statement shall be eligible for CAREWare training. CAREWare training is conducted by the database administrator or his or her designee only.

SecurID cards and personal identification numbers (PINs) may never be shared. If a user leaves a Provider, that user's replacement must submit the paperwork to transfer the ID. Providers will contact the CAREWare database administrator within 24 hours of an employee's final exit, so that the user's account can be locked until it is reassigned.

No user shall knowingly falsify data entered into CAREWare.

Users shall not share data from CAREWare with individuals for personal use or to any individuals who have no duties related to the data entered in CAREWare.

Client-level demographic, clinical, and service data shall be collected on all clients receiving Part B case management services, in accordance with current data collection protocols and definitions outlined in the CAREWare User Manual.

Providers shall have representation at periodic CAREWare user trainings, or arrange for other training and assistance from the CAREWare database administrator.

Client demographic data shall be reviewed and updated as needed, and at least annually.

- U. Required Meetings.** At least one administrator from the Provider agency shall attend training offered by the Part B program on contractual expectations and deliverables.

The Provider shall ensure that at least one staff member participates in each Part B provider meeting, in order to gather and share information.

The Provider shall ensure that at least one staff member participates in each Ryan White Advisory Committee meeting, in order to contribute to program development.

The provider shall ensure that at least one member of the Consumer Advisory Board, or other designated consumer of services, participates in each Ryan White Advisory Committee meeting.

- V. Client Mailings.** The Provider shall complete additional client mailings on behalf of the Department, upon request, and within the timeframe specified by the Department. The Department will provide at least five business days for agency processing. Mailings may include client satisfaction surveys, needs assessment surveys, conference and event mailings, etc.

- W. Payer of Last Resort.** In addition to the provisions in Rider D, 15, Revenue Maximization: The Provider shall provide financial records during annual site reviews demonstrating that Ryan White is the payer of last resort.