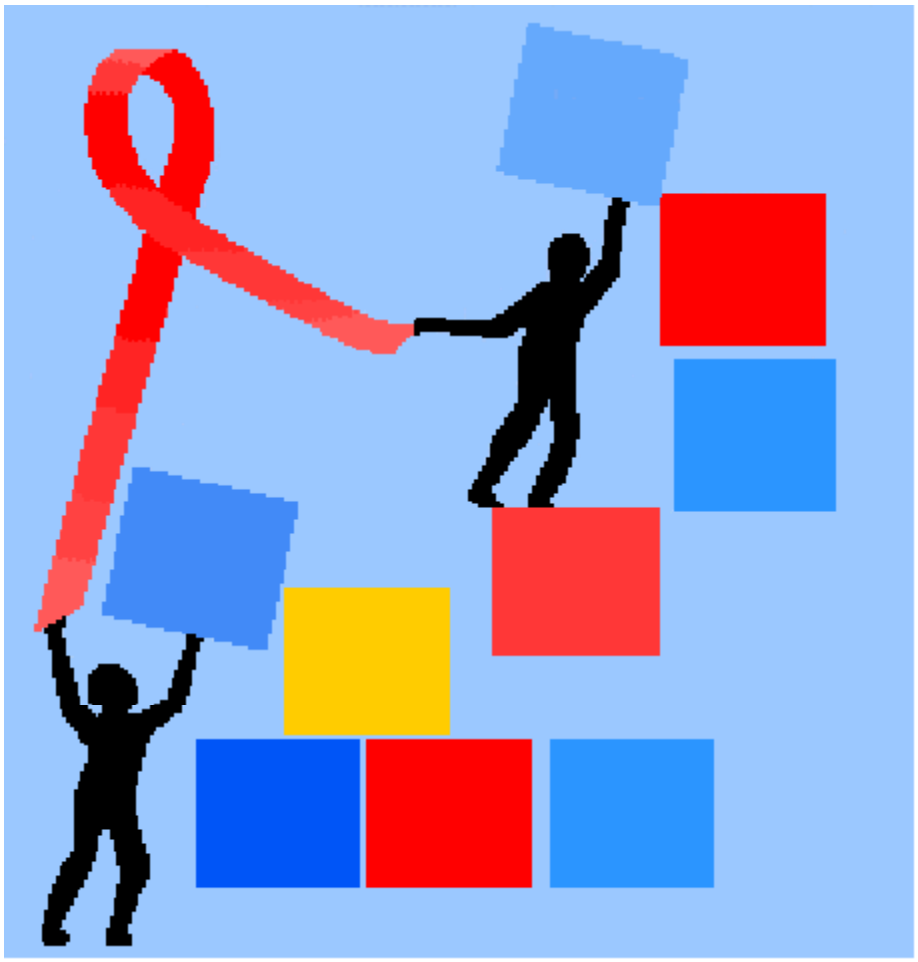
CHAPTER 5

Care Planning, Principles and Services



CARE PLANNING

Comprehensive planning is the creation of a "road map" for the development of a system of care (HRSA, Ryan White CARE Act Title II Manual, 1998). Building upon Iowa's epidemiological data and other needs assessment information, the planning process examines HIV care needs for Iowa and assesses the resources available to meet those needs and to overcome barriers to service provision. The comprehensive plan assists in setting long-term goals and sets guidelines for resource allocation. This section presents information on care planning in Iowa.

In 2001, the Iowa Department of Public Health (IDPH) and the Iowa HIV Community Planning Group (CPG) decided to link prevention and care planning activities. For the purposes of planning, CPG defines care as access to primary medical care. Enhanced integration of prevention and care programs with other programs that serve people who are HIV infected, or at increased risk, is a priority with the IDPH and the CPG. In Iowa, with relatively low incidence of HIV infection, the linkage of prevention and care services is critical to preventing further spread of HIV. The populations increasingly at risk for HIV infection need to be reached in creative ways, particularly in the rural parts of the state where people at risk are widely scattered. These individuals and others at continuing risk are often alienated from, or suspicious of, traditional medical, psychological, and social services. As the planning body, the HIV CPG provides recommendations to the Iowa Department of Public Health on HIV care and treatment issues. During 2002, the IDPH and CPG were involved in the development of the Statewide Coordinated Statement of Need, and assisted with Needs Assessment activities.

Long-Term Goals

The long-term goals of the Care committee are to collaborate with IDPH, the Case Management Ad Hoc Committee, and other CPG sub-committees

- in the development of Ryan White case management standards
- to create a Ryan White case management manual
- to establish guidelines so that consortia are accountable for providing non-duplicative services reflective of community needs
- to identify gaps in Ryan White CARE services
- to develop strategies to overcome identified gaps
- to develop an orientation about Ryan White Title II CARE services
- to maintain a current list of other financial and community resources available to people living with HIV disease
- to clarify allowable Ryan White Title II service categories

RYAN WHITE CARE ACT

The populations hit hardest by the AIDS epidemic are those at high risk for poverty, those who lack health insurance, and those who are disenfranchised from the health care system (Health Resources and Services Administration (HRSA, 2002). In August 1990, Congress enacted the Ryan White CARE Act to improve the availability of care for low-income and uninsured or underinsured individuals and families affected by HIV disease. Congress reauthorized the CARE Act in May 1996 and again in October 2000. Programs under the CARE Act include:

- Title I – Provides emergency assistance to Eligible Metropolitan Areas (EMAs) that are most severely affected by the HIV/AIDS epidemic.
- Title II – Provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the US Virgin Islands, and five newly eligible US Pacific territories and associated jurisdictions. Title II also funds the AIDS Drug Assistance Program (ADAP). Title II funds may be used to provide a variety of services (see **Appendix A**). In addition, funds are used by HIV Care Consortia to assess needs and to contract for services.
- Title III – Provides comprehensive primary health care for individuals living with HIV disease.
- Title IV – Provides services to women, infants, and youth living with HIV disease. Services include primary and specialty medical care, psychosocial services, logistical support and coordination, and outreach and case management.
- AIDS Education and Training Centers (AETC) – Provides multi-disciplinary education to health care providers to counsel, diagnose, treat, and medically manage individuals with HIV disease, and to help prevent high risk behaviors that lead to HIV transmission.
- Dental Reimbursement Program (DRP) – Supports access to oral health care for individuals with HIV disease, by reimbursing dental education programs for non-reimbursed costs incurred in providing such care.

Iowa receives Title II, Title III, AETC and DRP.

Nationally, the CARE Act reaches more than 500,000 people living with HIV each year. In 2002, 650 Iowans received services through the Ryan White Title II Services and 295 received prescription drugs through the AIDS Drug Assistance Program (ADAP) (IDPH, 2002). The CARE Act serves as the payer of last resort for Persons Living With HIV (PLWH) who are uninsured or have inadequate insurance and cannot cover the costs of care on their own, or because no other source of payment for services is available.

In 2002, 18 percent of Ryan White Title II funds were spent for prescriptions, medical care, and support services for women, infants, and children. IDPH predicts that 19 percent of Title II funds will be spent on women, infants, children and youth during 2003.

Over the last few years, clinical HIV care has undergone a revolution. Highly active antiretroviral therapy (HAART) is credited with reducing mortality and improving the quality of people's lives. Enhanced management of opportunistic infections and supportive care are important elements in the HIV chronic care treatment continuum. As clients live longer, many have only partial disability and limited or no access to Medicaid or other health coverage. The complexities of treatment options are a significant factor affecting clients' ability to adhere to

prescribed procedures. Social factors, adequacy of insurance, and co morbidities such as substance abuse, mental illness, or homelessness, influence a client's ability to follow a treatment regimen.

The resources necessary to provide the appropriate medical and care services to manage HIV infection are extensive. The physical size of Iowa, coupled with a limited number of providers, has resulted in the formation of both formal and informal programs and partnerships that support HIV/AIDS care services. While issues such as adequate and affordable housing, poverty, non-medical transportation, and discrimination are not directly addressed by the CARE Act, they remain critical concerns in achieving appropriate care outcomes.

HIV CARE CONSORTIA (Title II funded)
In cooperation with designated lead agencies, the IDPH has established four HIV Care Consortia (11 providers) that encompass all 99 counties of the state. These consortia provide essential health and support services, such as case management, emergency financial assistance, food bank assistance, housing assistance, and counseling, to financially eligible clients living with HIV. In 2002, 650 clients received services. The services are widely publicized to providers of health care and HIV support services throughout Iowa. An HIV/AIDS Directory includes both prevention and care providers, and is distributed to Counseling, Testing, and Referral sites, prevention and care providers, clients, and the general public.

ADAP (Title II funded)
ADAP is administered by IDPH through the use of one contracted centralized pharmacy that distributes drugs to clients statewide. A separate advisory committee, the Ryan White AIDS Drug Assistance Program (ADAP) Advisory Committee, provides periodic review of ADAP, including the ADAP formulary. Thirty-three HIV-related medications are provided to individuals with HIV whose income does not exceed 200 percent of the federal poverty level. In 2002, 295 individuals received ADAP assistance.

TITLE III
This title supports outpatient primary medical care and Early Intervention Services (EIS) to people living with HIV disease through grants to public and private non-profit organizations. The four Title III clinics in Iowa are located in Davenport, Des Moines, Iowa City, and Sioux City.

OTHER FINANCIAL ASSISTANCE AND COMMUNITY RESOURCES

Additional financial assistance may be available to help pay medical bills, provide income if unable to work, or help in an emergency. Financial assistance programs vary from county to county and state to state. Community resources may also be available to provide home nursing care, homemaker services, support groups or volunteer support services.

HOPWA

Housing Opportunities for Persons With AIDS (HOPWA) is a program funded by the US Department of Housing and Urban Development (HUD). The program is designed to help very low-income individuals who are living with HIV/AIDS to stabilize their housing, a key to health and well-being. Each community uses HOPWA funds to best match the needs of those they serve. Examples of HOPWA services provided in Iowa include rental assistance, utilities assistance, short-term financial assistance, mortgage assistance, housing support services and case management.

MEDICAID/TITLE XIX FINANCIAL ASSISTANCE PROGRAMS

These financial assistance programs are administered through the Department of Human Services.

A. **FAMILY INVESTMENT PROGRAM (FIP), replacement for AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)**
   FIP provides cash payments and usually Medicaid health care coverage to families with dependent children and limited income and resources. The monthly cash payment is determined by the number of members in a family, current income, and resources.

B. **MEDICALLY NEEDY PROGRAM**
   In Iowa, the Medically Needy Program is a health care program for people who a) are under 21 or over 65 years of age, pregnant, blind, and/or disabled, b) have limited resources and income, but exceed the guidelines for Social Security Income (SSI) and Family Investment Program (FIP). Medically Needy is a program designed to provide medical coverage through Medicaid.

C. **MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD)**
   Many persons with disabilities may be able to work and maintain medical assistance coverage. Eligibility will be determined by a variety of qualifications. Some of these requirements include disability; under age 65; earned income from employment or self-employment; required to pay a monthly premium when monthly gross income is above 150% of the federal poverty level (currently $1123.00). Premiums are calculated based **only** on the gross income of the disabled individual. Patients enrolled in Ryan White II may be eligible to receive premium assistance.

D. **AIDS/HIV WAIVER PROGRAM**
   The AIDS/HIV HCBS (Home and Community-Based Services) waiver pays for services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.

MEDICARE

Medicare is available for persons who are at least 65 years old and eligible to receive Social Security benefits, or have been on Social Security Disability Insurance for two years.

Medicare has two parts: Medical insurance and Hospital insurance. Hospital insurance provides 60 days of fully-covered hospital care per spell of illness, after a deductible is met. Then it provides an additional 30 days of hospital coverage with a co-payment; 100 days of skilled nursing facility care; coverage for medically necessary hospital equipment; and in-home skilled nursing care.
There is a premium for "Part B" of Medicare. Medicaid can pay this premium if an individual meets income guidelines.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)
SSDI provides monthly cash benefits if a person is considered disabled for 12 months or longer and has earned enough work credits by paying into "FICA." Monthly payments are based on age, years of employment, and salary. Medicare eligibility begins after the 24th month of SSDI eligibility.

SUPPLEMENTAL SECURITY INCOME (SSI)
SSI guarantees a person a minimum monthly income if over 65, blind, or disabled for 12 months or longer and determined to have limited income and resources. Iowa provides Medicaid health care coverage for persons receiving SSI.

STATE PAPERS
State papers may cover the cost of health care services and medications received from the University of Iowa Hospitals and Clinics. Transportation, meals, and lodging costs resulting from the need to receive health care services at the UIHC will also be covered. To be eligible, a person must be a legal resident of Iowa, have unpaid health care expenses from the University of Iowa Hospitals and Clinics, and meet the income and resource requirements determined by county of residence.

SUPPLEMENTAL/EMERGENCY FUNDS
Community AIDS organizations may have limited additional money from the Ryan White CARE Act federal funding, or locally-generated emergency funds. The Clinic Social Worker in each community will be aware of these services.

CARE PRINCIPLES

In 1997, the administrative agency for the Ryan White CARE Act, HRSA, released the following program principles. These principles, along with the Strategies for Prevention Interventions and Community Endeavors (SPICE) principles, presented in Chapter 4, guide care planning in Iowa.

The growing impact of the HIV/AIDS epidemic among underserved minority and hard-to-reach populations requires states to

- assess the shifting demographics of new HIV/AIDS cases; and
- Adapt care systems to the needs of emerging communities and populations; with a priority focus on PLWH who know their HIV status and are not in care.

Ensuring access to existing and emerging HIV/AIDS therapies, including new combination antiretroviral therapies and prophylaxis/treatment for opportunistic infection requires states to

- recognize the role of primary care in overcoming barriers to accessing therapies;
- recognize the role of support services in overcoming barriers to accessing therapies; and
- establish quality management programs.

Changes in the financing of HIV/AIDS care, particularly Medicaid managed care requires that CARE Act providers adapt to managed care environments and coordinate services with other Federal/State/local programs.

The increased importance of documenting outcomes from the investment of CARE Act resources requires states to

- describe the impact of Title II funds in establishing, maintaining, and expanding their continuum of care;
- establish quality assurance mechanisms; and
- establish evaluation mechanisms to assess the effect of funds on the continuum of care.

In addition, in Iowa persons living with HIV/AIDS must

- be equal and participate in the planning, implementation, and evaluation of care services;
- be complete partners in their individualized plan of care;
- be assured of confidential medical, supportive, and social services;
- have access to the most advanced quality medical and dental care available;
- have access to patient-focused and/or family-centered care;
- be provided services that facilitate and enhance independence, individual rights, and choices;
- have access to high quality, comprehensive, and supportive social services;

- have access to direct services that meet statewide minimum standards;
- receive services that are culturally and linguistically appropriate, free of discrimination based upon gender, age, sexual orientation, race, ethnicity, criminal history, substance use history, or ability to pay, with all known and perceived barriers minimized wherever possible.

BARRIERS TO CARE SERVICE DELIVERY

The following identifies Iowa's current crosscutting issues affecting PLWH, and a discussion of barriers that contribute to the difficulty faced by PLWH in accessing services (Statewide Coordinated Statement of Need [SCSN], 2002).

CHANGING NATURE OF HIV DISEASE

As a result of new drug therapies, HIV is moving closer to becoming a manageable and chronic, though still incurable, illness. Challenges and complications exist with this new long-term reality, including:

- Caseloads for Ryan White CARE Act (RWCA) grantees increasing as the number of persons living with HIV has increased.
- Financial constraints increasing the burden on already limited systems.
- An increase in hepatitis C co-infection and the complications that accompany co-infection.
- Long-term adherence to medication regimens
- Complacency about maintaining safe behaviors.

RURAL ISSUES

The rural nature of Iowa presents challenges for PLWH. Ongoing issues include having to travel long distances for regular medical care or to participate in support and planning groups. Concerns exist surrounding confidentiality when receiving testing, care, and support services in small towns. Rural PLWH do not have equal access to medical, social, or legal services as do their urban counterparts.

CHANGING NEEDS OF THOSE AFFECTED BY THE EPIDEMIC

An increasing number of people infected with HIV have a combination of complex social and health needs including homelessness, chemical dependency, mental illness, physical disabilities, poverty, and language barriers. While the reported number of people of color with HIV in Iowa is small, the rate of infection in African American and Hispanics is 12 times that of Caucasians.

SOCIOECONOMIC BARRIERS

Limited financial resources, cuts in social welfare entitlement programs, and inadequate health insurance, including prescription drug coverage and long-term maintenance, present barriers to individuals seeking to access essential HIV services. There is also a lack of consistent emergency medical coverage across the state. Fiscal barriers are compounded by the additional challenges of substance abuse, multiple HIV diagnoses in a family, and an array of mental health challenges that contribute to difficulty in accessing services. Iowa is experiencing an increase in its non-U.S. born population, both documented and undocumented who are in need of financial, medical, and social services.

RACIAL, ETHNIC, CULTURAL, & GENDER/SEXUAL ORIENTATION SPECIFIC BARRIERS

Insufficient access to a broad comprehensive health care and social service system creates barriers to service for different ethnic and racial minority groups. There continues to be a need

for funding for health and social service providers to provide culturally appropriate and competent care. Men who have sex with men, people of color, women, mentally and physically disabled individuals, and people whose first language is not English, are especially vulnerable to service barriers in Iowa.

GEOGRAPHIC BARRIERS

There is a need for more trained HIV specialists in Iowa. Primary care physicians and other health care professionals often have limited knowledge of HIV and AIDS. There is limited access to infectious disease specialists, as well as complete, coordinated and consistent services. People in rural areas struggle with the lack of adequate choices in medical care within a reasonable distance.

STIGMA, SHAME, AND FEAR OF DISCLOSURE

Stigma, shame, and fear of disclosure are barriers to accessing services for both clients and service providers. In rural areas, the small number of people infected with HIV contributes to a sense of aloneness and isolation. Fear that one's HIV status, sexual orientation, drug use history, and/or criminal history may be disclosed or not kept confidential, may prevent individuals from accessing care.

CONSUMER CONFIDENCE/EXPERIENCE AND KNOWLEDGE REGARDING THE HEALTH CARE SYSTEM

Due to the increasing number of clients born in developing third-world countries, many clients lack knowledge of current health care system. They avoid accessing health care, fearing that receipt of care will jeopardize their immigration status. Other clients have had previous negative experiences in accessing care and are reluctant to seek care services.

COMPETING NEEDS/OVERRIDING DAILY LIVING ISSUES

Competing needs such as low income, unemployment, limited disability benefits, unstable housing, homelessness, parenting and childcare issues, severely affect an individual's ability to seek care services and adhere to treatment plans.

LACK OF INSURANCE OR ABILITY TO PAY FOR SERVICES

Clients are reluctant to seek care services due to limited insurance benefits, lack of coverage, or having no financial resources to pay for the service.

LACK OF AFFORDABLE HOUSING AND TRANSPORTATION

There is a lack of affordable and available housing, transportation and other resources to meet client needs.

STRATEGIES TO OVERCOME BARRIERS TO HIV CARE SERVICES

Over the last few years, clinical HIV care has undergone a revolution. Highly active antiretroviral therapy (HAART) is credited with reducing mortality, and improving the quality of people's lives. While HAART is the most visible intervention, enhancing management of opportunistic infections and supportive care have been emphasized as important elements in the chronic care continuum of HIV treatment. As clients live longer, many have only partial disability and limited or no access to Medicaid or other health care coverage. The complexity of treatment options significantly affects clients' ability to adhere to prescribed procedures. Social factors, inadequate insurance, and co morbidity, such as substance abuse, mental illness, or homelessness, influence clients' capacity to follow treatment regimens.

CONTINUUM OF CARE

Continuum of care services and funding streams must adapt to and reflect this new reality. Increasing access to treatments and services, educating clients and service providers, and empowering persons living with HIV to advocate for themselves and for changes in the care system can accomplish this.

RESOURCES

The resources necessary to provide appropriate medical and care services to manage HIV infection are extensive. The physical size of Iowa, coupled with a limited number of providers, has resulted in the necessity to develop formal and informal programs and partnerships that support HIV care services. Issues such as adequate and affordable housing, poverty, non-medical transportation, and discrimination are critical concerns in achieving appropriate care outcomes.

CARE SYSTEMS

Current care systems must build capacity to serve rural clientele and to educate communities in which they live to help alleviate some of the social stigma surrounding HIV. They must build capacity and cultural competency to serve a diverse clientele that includes women, out-of-home and street-involved youth, those with incarceration histories, injection drug users, ethnic/racial minorities, non-English-speaking persons and undocumented clients. Alliances and partnerships must be created and maintained among HIV/AIDS and chronic disease clinics, and social service systems. These partnerships must share the primary goal to more effectively assist clients with complex needs to improve access to care services and to encourage clients to adhere to prescribed treatments.

LINKING PREVENTION AND CARE

Integration of prevention and care services is a statewide goal in Iowa. The HIV Community Planning Group has incorporated care planning into its existing infrastructure. HIV-positive persons are prioritized for prevention services. Counseling and testing, partner counseling and referral services, prevention case management, and early treatment of HIV are also linked.

IDENTIFYING PLWH NOT IN CARE

IDPH has worked with consortia to reach underserved, difficult to reach persons and link them to ADAP services. Further strategies will be developed to identify and determine the needs of

clients who know their status and are not in care. The Care Committee will develop a questionnaire to determine unmet care needs. The committee has been working with the HIV/AIDS Program Surveillance Coordinator to measure unmet need utilizing the number of People Living with AIDS (PLWA) and People Living with HIV non-AIDS/aware (PLWH non-AIDS aware) and percent of PLWA and PLWH non-AIDS/aware meeting primary care definition. This information, once gathered, will be linked to our investigations into reasons for unmet need for care. The investigations will focus on structural and individual barriers that keep people from care. They will be qualitative client interviews and focus groups.

GAPS IN SERVICES NEEDED BY PLWH

ACCESS TO HEALTHCARE

Continued expansion of the Ryan White HIV care and drug assistance programs is needed to close critical gaps that impact people's abilities to access primary and specialty care, dental care, mental health services, and medications. A significant number of people receiving services are either underinsured (limited coverage), or uninsured (no coverage). People with limited or no coverage may not seek routine HIV care because of cost. High deductibles and co-pays are barriers to non-urgent care. For the underinsured, dental, mental health, home health care, prescription services, and substance abuse treatment may not be covered. Clients accessing state programs may deal with complex spend-down rules for eligibility, or face limitations on covered drugs and mental health services.

BASIC SURVIVAL NEEDS

The overlay of poverty and service gaps for people living with HIV cannot be overstated. A significant number of people with HIV are living below the poverty level. For these individuals, the need for routine medical care is superseded by day-to-day survival needs of food, shelter, and safety. Lack of routine and preventive HIV care leads to the development of opportunistic infections, hospitalizations, and mortality. To prevent unnecessary hospitalizations and mortality, it is essential that Iowa continues to receive funding for housing assistance programs, case management and support services, and health care coverage.

EDUCATION AND INFORMATION GAPS

As increasingly complex medication regimens become the standard of HIV care, up-to-date information and education is a necessity for medical providers, social services professionals and people living with HIV. Provider awareness of current treatment regimes can directly impact the lifespan of those living with HIV. Clients of varying literacy levels, or whose primary language is not English, need access to treatment information. Bilingual and culturally-competent providers, who are knowledgeable about HIV and sensitive to cultural issues, are needed.

MENTAL HEALTH SERVICES

The need for quality, comprehensive mental health services are becoming more urgent as the numbers of patients diagnosed with both HIV and psychiatric illnesses increases. Mental health services need to be coordinated with medical and social services.

HIV treatment is complex and its affect on individuals can be unpredictable. Sexuality, multiple losses, fear, and stigma issues all impact the mental health of individuals with HIV. Professional and peer support programs are needed to help individuals and families cope with the range of psychosocial issues arising from being infected or affected by HIV. Options should include models that are creative and varied in approach to best meet the needs of the community.

SUBSTANCE ABUSE SERVICES

Lack of access to alcohol and drug treatment services severely affects the ability of people living with HIV to manage a dual diagnosis of HIV and substance abuse. Gaps in services impact providers' ability to offer high quality, consistent medical care to people with HIV who are abusing substances.

EMPLOYMENT SERVICES

As the quality of life for those living with HIV continues to improve, and as their lifespan continue to be extended, appropriate rehabilitation and employment services need to be developed. Supportive services such as job training, retraining, and rehabilitative case management must be available for those who have difficulty seeking or maintaining employment. Access to General Education Degree (GED) courses or English as Second Language (ESL) courses may also be needed.

HIV/AIDS CASE MANAGEMENT

Case management is a formal and professional service that links clients with chronic conditions and multiple service needs to a continuum of health and social service systems. Case management strives to ensure that clients with complex needs receive timely coordinated services that enhance a client's ability to function independently as long as it is practical. Case management assesses the needs of the client, the client's family, and the client's support system, and then arranges, coordinates, monitors, evaluates and advocates for a package of services to meet the client's specific needs.

During the early years of the HIV epidemic, case management was primarily concerned with coordinating support services for a terminally ill population. Case managers provided support to assist people with HIV and their families to cope with a disease that ultimately would lead to death. While some levels of nursing and medical case management were available, the focus of case management was the coordination of psychosocial support services.

Changes in the HIV epidemic have required providers in Iowa to examine how HIV services are delivered to their communities. Case management has expanded to incorporate the principles of chronic disease management. New treatments require a strong link between the provision of medical care and wrap-around services. The demographics of infected populations are changing. Providers deal with multiculturalism, women's issues, children and youth, substance abuse, mental illness, homelessness and persons living in poverty.

Title II of the Ryan White CARE Act mandates case management in rural communities. Traditional activities of case management are intake, assessment, care plan development and implementation, referral, follow up and monitoring, and discharge. In Iowa, case managers also provide services such as eligibility determination, benefits monitoring, and benefits disbursement.

Care coordination systems are being established in Iowa. Care coordination incorporates case management with access to care, outreach, information and referral, eligibility determination, benefits coordination, adherence and compliance activities, and primary care coordination. Care planning, which was merged with HIV prevention planning in 2001, takes all of these components into consideration during the planning process. Case management and care coordination activities require standardized definitions, well-defined roles and responsibilities, and the development of standards and performance outcomes.

CASE MANAGEMENT STANDARDS

Standards provide a direction to the practice of HIV case management. They provide a framework for evaluating the practice of HIV case management and define the professional case manager's accountability to the public and to the client. Case management standards can be divided into two categories: *Standards of Care and Standards of Performance*. *Standards of Care* delineates a competent level of services, as demonstrated by the process of delivering the service. *Standards of Performance* defines a competent level of behavior in the professional role that includes quality of care, qualifications, collaboration, legal ethics, advocacy, and resource utilization.

In 2003, the Iowa Case Management Task Force incorporated *Standards of Care* and *Standards of Performance* into one set of standards for the core activities of case management:

- Initial Client Contact
- Intake/Assessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- On-going Reassessment
- Transfer and Discharge

Standards

The case management standards presented in the following section define the:

- PURPOSE of each core activity
- PROCESS, or step-by-step method to conduct the activity
- CRITERIA, or the specific activities, required to meet the Standard
- DOCUMENTATION, if required

INITIAL CLIENT CONTACT

Standard:
Each prospective client who requests or is referred for case management services meets with agency staff to provide basic demographic information.

The Initial Client Contact is necessary to determine whether the client is in a crisis situation and/or requires immediate direct service or referral. During the Initial Client Contact, agency staff will gather basic demographic information. Based on this information, agency staff can choose to 1) provide immediate assistance through the resources of the agency, 2) refer the client to another agency, or 3) continue the enrollment process by completing the client Intake/Assessment.

Process

1. Initial Client Contact is initiated by a prospective client, his or her representative, or a third-party referral (verified at least verbally by client) to the case management agency.

2. A designated individual with appropriate training and skill screens the service request or referral for basic admission criteria, and assesses the need for immediate intervention.

3. Critical demographic and case specific information is collected directly or indirectly from the client or the referral source, and the prospective client is informed of agency services and limitations.

4. The client is referred to the case manager at the agency or another agency for Intake/Assessment.

Criteria

1. The person conducting the Initial Client Contact provides prospective clients with a description of the services available from the agency, as well as services available from other agencies.

2. The person conducting the Initial Client Contact documents recommendations and referrals.

Information to be documented:

a) Name, address (mailing if different), phone, message phone
b) Location where client prefers/declines to be contacted
c) Age/Date of Birth
d) Gender
e) Racial and/or ethnic identification
f) Source of referral

g) Recommendations and referrals
h) Date of Initial Client Contact

INTAKE/ASSESSMENT

Standard:
Each prospective client who requests or is referred for case management services will be properly screened and evaluated through a face-to-face Intake/Assessment process designed to gather information for future service delivery and to assess biopsychosocial needs.

Purpose of the Intake/Assessment

An Intake/Assessment is an information gathering process which includes a face-to-face interview between a client and case manager, and acquisition of secondary data from health and human services professionals and other individuals. It is a cooperative and interactive process during which a client and case manager collect, analyze, synthesize and prioritize information that identifies client needs, resources, and strengths, for purposes of developing a *Care Plan*. The Intake/Assessment establishes the basis for development of rapport and trust, which are essential elements of successful case management. Also, it allows the client to interact with agency staff and to consider the ramifications of his or her participation in the program.

Informed Consent

Enrollment into a case management program is often the client's first encounter with the HIV services system. The client's *Informed Consent* to participate in the case management program should be obtained at this time. In the process of acquiring the client's informed consent, it is important to ensure that the client understands the *Grievance Procedure* and the right to refuse any and all services. The client may exercise this right at any time during his or her participation in the case management program.

Confidentiality

As part of enrollment into the case management program, clients are informed of the right to *Confidentiality,* and the legal limitations placed on the case manager. It is important not to assume that anyone - even the client's partner or family member - knows that the client is HIV positive. Discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone). Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual is living with HIV disease or receiving social services.

Release of Information

Another element of the enrollment process is the *Release of Information* form, on which the client authorizes in writing the disclosure of certain information about his/her case to another party (including family members). Included on the form are the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. The discussion should include a description of the *Release of Information*, its components, and ways the client can nullify it.

Client's Rights and Responsibilities
An additional document presented to the client is the *Client's Rights and Responsibilities* form. The case manager reviews all of the rights and discusses the responsibilities as part of the overall discussion of a client's participation in the case management system. A copy of the *Client's Rights and Responsibilities* form, signed by the client, should remain in the client's file, and a copy should be given to the client to keep.

Program Offerings and Limitations
The client will be provided a clear explanation of the range of services offered by the case management program, and the role of the case manager. The client or his/her support persons might have questions about the program and the case manager's involvement with the client. It is important for the case manager to make the client aware of the program's limitations as well as its offerings. This information must be provided during the Intake/Assessment to avoid client and agency problems that inappropriate expectations can cause later on. Once the Intake/Assessment is completed, both the staff and client have the information needed to determine whether further assessment is needed.

Qualifications
The Intake/Assessment should be performed by a qualified case manager who exemplifies a high degree of interpersonal skill and empathy, and in-depth knowledge of the HIV/AIDS social service system. She/he should also have the ability to assess for immediate need, with referral to the appropriate agencies/services. Local agencies will decide, based on agency and client needs, whether to allow drop-in Intake/Assessment, and whether to have multiple sessions. Intake/Assessment is directed at reaching mutual agreement between the case manager and client concerning priority needs and client strengths and limitations.

Process

1. The Intake/Assessment is conducted by case managers and is performed in accordance with the Iowa HIV Case Management Standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements and confidential meeting location.

2. The face-to-face interview is conducted at a site mutually acceptable to the client and case management staff.

3. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. Equally important is ongoing collaboration between the case manager and other health and human service providers and individuals involved with the client. Case conferencing and consultation with other agencies providing services to the client should be an ongoing activity of case management. Appropriate documentation of these activities should be included consistently in the client's file.

Criteria

1. The client Intake/Assessment is conducted in face-to-face meeting(s) between the client and case manager, commencing no later than ten (10) working days following the Initial Client Contact unless client's specific situation dictates otherwise and rationale is documented in the client record. The Intake/Assessment should be completed within 60 days from its initiation.

2. Client needs are systemically assessed and documented. This requires active participation of the client, assessment worker, and other individuals agreed to by the client. Following is a list of areas to be investigated. Include both the client's self-reporting and official documentation. It is important to note that not all clients will have needs in every category.

    a. Health Status & History
        i. date of HIV and/or AIDS Diagnosis
        ii. current treatments
        iii. medications
        iv. side effects
        v. adherence concerns
    b. Financial
        i. income
        ii. benefits
        iii. insurance
        iv. other forms of financial assistance
    c. Housing
        i. quality
        ii. accessibility
        iii. residential support
    d. Vocational
        i. current employment
        ii. work history
        iii. accommodations
    e. Educational
        i. status
        ii. literacy
        iii. communication
    f. Tobacco, alcohol, drug use
    g. Mental Health
        i. emotional
        ii. cognitive
    h. Cultural, ethnic, racial considerations
    i. Communication skills, literacy, and/or translation requirements
    j. Social relationships and support
        i. informal care givers
        ii. formal service providers
        iii. significant issues in relationships

iv. social environments
k. Accessibility of health and community resources
l. Social activities
i. recreation & leisure
ii. social network
m. Legal
i. guardianship
ii. power of attorney
iii. parole officer
iv. other pertinent HIV/AIDS laws
n. Spirituality/religion
o. Prevention needs
i. knowledge of HIV transmission
ii. risk reduction
iii. assess client's need to review Iowa transmission law (see **Appendix B**)
p. Activities of daily living
q. Transportation
r. Other

Documentation of Elements of the Assessment

a) Documentation of HIV status (MANDATED)-requirements are listed on the next page (f) iii)
b) Primary Care Physician/clinic, address, phone
c) Other health care providers (past and present), address, phone
d) Release of Information
e) Documentation of financial information/verification/proof of income
f) Documentation of health insurance (if applicable)
g) Photo ID (if available)
h) Social Security Number (if available)
i) Client Rights & Responsibilities
j) Informed consent
k) Client grievance procedures

To be completed as part of the Assessment

a) Health assessment and medication adherence
b) Psychosocial assessment (conducted face-to-face with the case manager)
c) Other assessment data (acquired from other professionals and sources, if necessary)
d) Problem/needs list
e) Completed enrollment checklist
f) Verification of HIV status
    i. Client self-report of HIV status (documented at intake/assessment)
    ii. Verification of client HIV status (must be obtained Within 30 days from the date of Intake/Assessment)
    iii. Acceptable verification includes at least one of the following:
        1. a copy of the client's seropositive test results from the test provider
        2. a signed document from a physician or his/her designee, verifying that the client is HIV positive
        3. lab results at any time during the client's lifetime, verifying the presence of the human immunodeficiency virus

Exemption from the requirement to secure verification of HIV status is granted when a person who is affected, but not infected, is determined to be appropriate for case management services. However, per HRSA guidelines, **when case management services are provided to a client who is affected but not infected, documentation in the client file must show that the services offered will directly benefit a person living with HIV**. Specifically, rationale will address one or more of the following:

i. How the delivery of case management services to the affected client will allow him/her to participate in the care of someone with HIV disease.
ii. How case management of the affected client will enable an infected individual to receive needed medical, support or housing services by removing an identified barrier to care.
iii. How case management of the affected client will promote family stability in coping with the unique challenges posed by HIV.

CARE PLAN DEVELOPMENT

Standard:

A Care Plan (the terms care plan, case plan or service plan may be used interchangeably) will be developed in an interactive process with each client of case management services. Development of the Care Plan is a translation of the information acquired during Intake/Assessment into specific measurable goals and objectives with defined activities and time frames to reach each objective.

Purpose of Assessment-Based Planning

For the most efficient use of time, and to achieve effective outcomes, a clear plan must direct the activities of the client and the case manager. This plan becomes the basis for evaluating what services were provided and whether they achieved the desired outcomes. Once the case manager has gathered sufficient information from the Intake and Assessment, this information will form the basis of the Care Plan. Within 10 working days following completion of the Intake/Assessment, a Care Plan should be developed by the designated case manager and recorded in the client record. The case manager has primary responsibility for development of the Care Plan, in conjunction with the client, other members of the support system, and other involved providers.

Elements of the Plan

The major components of the Care Plan include:

1. Identification of agreed-upon client needs and goals
2. Identification of barriers
3. Quantifiable objectives with specified action steps
4. Designated individual(s) who will perform each activity
5. Time line for each step
6. Client and case manager signatures and date

Client Involvement in Planning

The Care Plan provides the basis from which the case manager and the client work together, as partners, to access the resources and services which will enhance the client's quality of life and his/her ability to cope with the complexity of living with HIV disease. The client and members of the support system play a vital role in development of the Care Plan. This process uses the inherent supports the client brings to the case management relationship. The process supports client self-determination whenever possible, and empowers a client to actively participate in the planning and delivery of services.

In setting up a Care Plan, the client and case manager must come agree about what tasks will be done by the case manager and what the client will do. Most clients will count on the case manager to guide them through the maze of the health and human services system, and to present options and help them develop contingency plans, should the initial efforts fail to produce the

desired results. It is important to set up a time frame within which progress toward the goals will be jointly assessed and revisions of the plan can be made.

The role of the case manager is one of resource coordination. During Care Plan development, when specific knowledge or skills beyond those of the case manager are needed, consultation with other professionals is sought with appropriate releases of information.

CARE PLAN IMPLEMENTATION

Standard:

Each client will receive assistance in accessing those services critical to achieving optimal health and well-being, in accordance with the Care Plan, and advocacy assistance when barriers impede access.

Tasks in Implementing the Plan

1. Service referral/brokerage/linkage
   - Making referrals
   - Reducing barriers/facilitating access
   - Follow-up after referral
   - Advocating with referral agencies when needed
   - Emotional support

2. Designating Roles
   The case manager and client will work together to decide *what* actions are necessary to accomplish each objective, and *who* will take responsibility for each task. The case manager will encourage and support clients to act on their own behalf whenever possible.

3. Referral
   The act of directing a person to a service, in person or by telephone, written, or other communication channel. Referral may be made (1) from one clinical provider to another; (2) within the case management system; (3) by professional case managers; (4) by program staff; or (5) as part of an outreach program.

   Referrals to outside agencies are often needed for specified services to meet the Care Plan objectives. Referral agencies should be assessed for their appropriateness to the client's situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered a part of the referral process. Any referral made should be appropriately documented in the client record.

4. Monitoring progress of the Care Plan
   Follow-up and implementation are inseparable. Through systematic follow-up the case manager and client discover whether the plan is working and when it needs revision. The Care Plan should be regularly reviewed to determine whether changes in the client's situation warrant changes in the plan, and whether the goals and objectives of the plan are being met in a timely manner and, if not, why not.

   Monitoring client satisfaction is an ongoing process throughout the delivery of case management services. It determines whether the mutually agreed-upon goals of the Care

Plan are truly meeting the needs of the client. At any point, this process may trigger a need for re-evaluation of the plan and/or the client and case manager working relationship.

5. Advocacy
   Advocacy is the act of assisting someone in obtaining needed goods, services or benefits (such as medical, social, community, legal, financial, or other services), especially when the individual has had difficulty obtaining them on his/her own. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Process for Implementing the Plan

1. Implement the Care Plan incrementally, allowing for full client participation. Aim to accomplish one objective at a time, while acknowledging the next tasks to be accomplished, except in emergency or highly urgent situations where multiple objectives may need to be implemented early in the Care Plan.

2. Case conferences and other forms of care coordination can help to ensure that all providers involved in a client's care and treatment work together to achieve the best mix of services and avoid duplication.

3. Successful implementation of the plan may require the case manager to take a more active role in helping the client identify problems that could impact the client's ability to fulfill his or her obligations to the Care Plan.

4. The Care Plan should be used as an important tool for helping the client cope with his or her problems and service needs. With proper support many clients are able to increase their coping skills and stabilize their life situation to avoid the cycle of moving from one crisis to another.

Documenting Implementation

Implementation of the Care Plan includes careful documentation in the progress notes of each encounter with the client, persons in his or her support system, and other providers involved with the client's care. Dates of contact, information on who initiated contact, and any action that resulted from the contact should be included in the documentation. All documentation should be signed and dated by the case manager.

CARE PLAN FOLLOW-UP AND MONITORING

Standard

Client and case manager will reassess the Care Plan goals and objectives at least every 6 months as a way to assess progress and the need for appropriate changes. The client and case manager will agree upon and sign the revised Care Plan.

Purpose of Follow-up and Monitoring

Monitoring is an ongoing process of data collection and analysis, resulting in

- evaluation of the effectiveness and relevance of the Care Plan
- evaluation of the level of client satisfaction
- measurement of client progress toward stated goals and objectives
- determination of the need for Care Plan revision

Goals of Follow-up and Monitoring

The overall goals of follow-up and monitoring are to:

- ensure the Care Plan is being implemented and is adequate to meet client service needs
- make sure the care and treatment the client receives from different providers are coordinated to avoid needless duplication of or gaps in services
- ensure that changes in the client's condition or circumstances are adequately addressed to avoid crisis situations
- maintain regular client and case manager contact to build trust, communication and rapport

Process

1. Either the case manager or the client can initiate follow-up.

2. Clients should be encouraged to contact the case manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems.

3. Careful planning by the client and case manager can determine how often contact is needed to minimize crisis situations and best meet the client's anticipated needs.

4. Follow-up and monitoring activities can occur through direct contact (i.e. face to face meetings, telephone communication) with the client, client and caregiver, parent or guardian. Client contact with the case manager often occurs on an ad hoc or drop-in basis. Follow-up can occur in the case manager's office, at the client's home or temporary residence, in the hospital or at other sites in the community.

5. Indirect contact with the client, client's family or caregiver, primary medical provider, service providers and other professionals also provides follow-up and monitoring information. This can happen through meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing.

6. To build an effective client-centered relationship, it is important that periodic follow-up and monitoring happen in face-to-face meetings with the client. This allows the case manager to offer emotional support, and assess the client's overall affect and general physical condition.

7. Identifying and contacting people previously enrolled in HIV care and treatment services, but lost to follow-up or not responding, may be a component of monitoring. This is accomplished through periodic review of client files and requests from medical providers or referral from other outreach activities. This information will be reportable, and evaluated periodically for effectiveness in re-enrolling clients with HIV in case management and primary care.

Criteria

1. The client and case manager will reassess the Care Plan goals and objectives at least every six months.

2. The client and case manager will agree upon and sign the revised Care Plan.

ON-GOING REASSESSMENT

Standard:

At least annually, clients receiving case management services will have their needs reevaluated through a comprehensive biopsychosocial reassessment.

Purpose of the Reassessment

Clients are reassessed to identify unmet and/or emerging needs, guide appropriate revisions in the Care Plan and inform them of decisions regarding discharge from case management services and/or transition to other appropriate services. Reassessment is conducted in the event of significant changes in the client's life, or as above.

Process

Reassessment is conducted by the case manager and is performed according to established standards and criteria. The process of reassessment should encourage active participation by the client and/or significant others, to include legal guardians, parents of minor children, and partner or spouse. Reassessment may involve the collaboration between case manager and other health and human services providers, individuals actively involved with the client, and client record review.

Criteria

1. Those receiving case management will be reassessed in the event of significant changes in the client's life or as defined in process.

2. Reassessment will involve the original assessment areas, and include Care Plan progress, changes, and mutually agreed-upon goals.

Documentation

1. Updated demographic data
2. Updated assessment data acquired from health care providers and other professionals and sources
3. Updated Care Plan reflecting the above input and review

TRANSFER AND DISCHARGE

Standard:

A systematic process shall be in place to guide transfer of the client to another program or case manager, and/or discharge from case management services. This process includes clear documentation of the reason(s) for discharge, notifying the client of case closure and the appeals process.

Conditions Under Which Transfer/Discharge Shall Occur:

1. Death of the client
2. Client moves out of the case manager's geographic service area
3. The client and/or client's legal guardian requests that the case be closed
4. Client makes fraudulent claims about their HIV diagnosis or falsifies documentation
5. Client enters prison

Conditions Under Which Transfer/Discharge May Occur:

1. Client is "lost to follow-up"
2. Client moves into a system of care which provides in-house case management
3. Client becomes self sufficient
4. Client is unwilling to participate in Care Plan
5. Client exhibits a pattern of abuse of agency staff, property or services
6. Client needs are more appropriately addressed by other programs

Process for Transfer/Discharge

1. Reason for discharge or transfer is discussed with the client. Other service provision options are explored and documented.

2. In instances where the case management agency initiates termination:
   a) The case manager consults with a supervisor about the intent to discharge the client.
   b) The client is informed of the intent to discharge, and provided information regarding appeal of that decision.
   c) The client is informed of other available community resources that may be able to meet his/her needs.
   d) In some circumstances, a client may be suspended from services for a specified period of time. Every effort should be made to assist the client in meeting expected program guidelines and becoming eligible for services.

3. A Discharge Summary, including careful documentation of reason(s) for discharge and a service transition plan is prepared.

Criteria

In instances where the client cannot be reached within 1 year, a letter indicating intent to discharge should be mailed to the client's last known mailing address. The letter should state that if the client has not responded within 30 days, their file will be closed.

Documentation

A Discharge Summary should be included in the Progress Notes in the client's file.

Case Management Timeline

Initial Client Contact (ICC)

↓

Initiate Intake/Assessment within 10 Working Days

↓

Complete Intake/Assessment within 60 Days (from ICC)

↓

Develop Care Plan within 10 working Days (from completion of Intake/Assessment)

↓

Reassess Care Plan at least every 6 months

↓

Comprehensive Reassessment at least Annually

DEFINITIONS

Adherence (Treatment Regimen) -- Following the recommended course of treatment by taking all prescribed medications, keeping medical appointments and obtaining lab tests when ordered.

Case managers can help clients identify and remove barriers that prevent them from taking medications properly and consistently. Maximizing the effectiveness of treatment depends on identifying all of the elements in clients' lives which affect their ability to follow the recommended course of treatment. This assessment should include six areas of client functioning: (1) education; (2) motivation; (3) self-efficacy; (4) barriers to performance; (5) remembering; and (6) side effects.

Advocacy -- Advocacy is the act of assisting someone in obtaining needed goods, services or benefits (such as medical, social, community, legal, financial, or other services), especially when the individual has had difficulty obtaining them on his/her own. Advocacy does not involve coordination and follow-up on medical treatments. (This should not be confused with appropriate Nursing intervention.) Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Americans with Disabilities Act (ADA) -- The ADA is a civil rights law passed by Congress in July of 1990 to protect people with disabilities from discrimination in public and private services and accommodations. Since HIV disease is considered a disability, ADA protections apply to persons living with HIV/AIDS.

Biopsychosocial -- a comprehensive picture of a person, containing information about her/his physical (bio), psychological (psycho) and social (socio)health.

Broker -- To act as an intermediary or negotiate on behalf of a client.

Care Plan -- A written plan that directs the activities of the client and the case manager. The Care Plan delineates the case management goals and objectives that link the client to the continuum of health and support services required to manage their disease.

Client Record -- A collection of printed and/or computerized information regarding a person using services currently or in the recent past.

Confidentiality -- The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his/her representative. Information may be released only in the following circumstances: (1) When a written release of information is signed by the client; (2) When there is a clear medical emergency; (3) When there is a clear and imminent danger to the client, case manager or others; (4) When there is possible child or elder abuse; and (5) When ordered by a court of law.

Coordinated health care -- Health care services related to the treatment of HIV/AIDS infection and HIV/AIDS associated complications, as well as the maintenance of health status.

Criteria -- Definition of specific, measurable outcomes expected from a Standard.

Cultural Competency -- The ability of service providers and others can accommodate language, values, beliefs and behaviors of individuals and groups they serve.

Demographic Information -- Descriptive information about a client, including, but not limited to, age, race/ethnicity and gender. This information provides a profile of people receiving services from a specific agency.

Emotional Support, Counseling and Therapy -- While the terms emotional support, counseling and therapy are often used interchangeably, they suggest activities with somewhat different purposes in the context of HIV/AIDS case management. All, however, should have as their ultimate goal the empowerment of clients.

Emotional support -- The ability of the case manager to listen and empathize is the essence of emotional support in the case management relationship. In cultivating a trusting relationship, it is important for the case manager to strike a balance between the empathetic role--using active listening skills, developing rapport, and providing emotional support-- and the objective role which requires engaging and encouraging the client toward concrete actions to achieve a desired outcome. Because case management is often defined as a task-oriented process, we tend to focus on the "doing" of tasks with the client, and forget the importance of "being present". Being truly available to offer emotional support is particularly important in situations where we do not have resources to meet clients' needs.

Counseling -- Counseling is a solution-focused helping process that is outer-directed—the focus is on "here and now" problems in living--with the goal of improving the client's ability to function in these areas. It is a strengths-based approach that enhances the client's capacity to envision solutions and to recognize and use internal and external resources available to him or her, including resources that have worked in the past in overcoming difficulties. One of the most common examples of counseling in a case management relationship is crisis intervention.

Therapy -- Therapy refers to professional mental health interventions aimed at reducing clinical symptoms that interfere with an individual's ability to meet the demands of daily life, and participate actively in his or her own health care. It falls outside the role of a case manager to provide mental health therapy to clients. Referring clients to appropriate mental health resources, and facilitating access to those services is the appropriate role for the case manager.

Grievance -- A verbal or written complaint or concern regarding a practice or policy of an individual or organization per the organization's policy.

Health Education/Risk Reduction - Activities which include information dissemination about methods to reduce the spread of HIV; HIV disease progression; and the benefits of medical and psychosocial support services. This activity does not include medication or treatment information, which is part of Adherence activities.

Multi-Disciplinary Team -- A team that includes professionals representing the disciplines required for a holistic approach to meeting the needs of a client, as identified through the Assessment. At a minimum, the team consists of the Medical Care Provider and the HIV Case Manager.

Process -- A step-by-step method to gather information or conduct an activity.

Quality Assurance/Improvement -- A method of program/service evaluation, which is designed to assure that the highest quality of services are provided to the client.

Ryan White CARE Act -- Passed by Congress in 1990, the purpose of this federal Act is to provide emergency assistance to communities that are most affected by the HIV epidemic and to make financial assistance available to state and other public or private nonprofit entities. This assistance provides for the development, organization, coordination and operation of more effective and cost-efficient systems for delivery of essential services to individuals and families with HIV disease.

Standard -- Authoritative statements by which a profession describes the responsibilities of its practitioners. A rule or basis of comparison in measuring or judging capacity, quantity, content, extent, value and/or quality.

Treatment Plan -- A written plan of treatment and therapy developed by a medical provider.

APPENDIX A

Glossary of HIV-Related Service Categories

Health Care Services

Ambulatory/Outpatient Medical Care: 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. This 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 and nutritional issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. *Primary Medical Care for the Treatment of HIV Infection* includes the provision of care that is consistent with the Public Health Service's Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Home Health Care: Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case-management team that includes appropriate health-care professionals. Component services include: durable medical equipment; homemaker or home-health aide services and personal care services; day treatment or other partial hospitalization services; intravenous and aerosolized drug therapy, including related prescription drugs; routine diagnostic testing administered in the home of the individual; and appropriate mental health, developmental, and rehabilitation services.

Note: Home and community based care does not include inpatient hospital services or nursing home and other long-term care facilities.

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

Nutritional Counseling: Services provided by a licensed registered dietician outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietician should be provided under *Psychosocial support services.* Provision of food, meals, or nutritional supplements should be reported as a part of the sub-category, *Food and/Home-Delivered Meals/Nutritional Supplements,* under Support Services.

Oral Health: Includes diagnostic, prophylactic and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Rehabilitation Services: Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low vision training.

Substance Abuse Services Outpatient: The provision of medical treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient setting rendered by a physician or under the supervision of a physician.

Substance Abuse Services Residential: The provision of treatment to address substance abuse issues (including alcohol, legal and illegal drugs), problems provided in an inpatient health services setting rendered (short term).

Treatment Adherence Services: The provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

Support Services

Child Care Services: The provision of care for the children of HIV positive clients while the clients are attending medical or other appointments. Note: This does not include daycare while the client is at work.

Child Welfare Services: Assistance in placing children younger than 21 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

Buddy/Companion Services: An activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

Case Management: A range of client-centered services that link clients with health care, psychosocial and other services. Ensures timely, and coordinated access to medically appropriate levels of health and support services, continuity of care, through ongoing assessment of the client's and other family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include (1) initial assessment of the service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of the services required to implement the plan as well as client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client specific advocacy and/or review of utilization of services.

Client Advocacy: The provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

Psychosocial support services: Individual and/or group counseling, other than mental health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education services that are provided to clients, families and household members, and/or other caregivers and focused on HIV-related problems.

Day or Respite Care: Home or community based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client.

Emergency Financial Assistance: The provision of short-term payments for essential utilities and for medication assistance when other resources are not available. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

Food Bank/Home Delivered Meals/Nutritional Supplements: The provision of actual food, meals, or nutritional supplements.

Health Education/Risk Reduction: The provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

Housing Services: The provision of short-term assistance to support temporary and/or transitional housing to enable an individual or family to gain and/or maintain medical care

Related housing services: Includes housing in medical treatment programs for chronically ill clients (e.g. assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for HIV-affected clients. This category also includes access to short-term emergency housing for homeless people. In addition, these services include assessment, search, placement, and the fees associated with the aforementioned. Services must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Legal Services: The provision of services to individuals with respect to Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services for guardianship or adoption of children after the death of their normal caregiver. See also, *Permanency Planning* and *Child Welfare Services*.

Outreach Services: Includes programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services (i.e. case finding), not HIV counseling and testing nor HIV-prevention education. Outreach services programs must be planned and delivered in coordination with local HIV-prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Broad marketing of the availability of health-care services for PLWH should be prioritized and funded as Planning Council or Consortium supported activities. HRSA/HAB Policy Notice 02-01 provides details on revised policy for the use of Ryan /HAB Web site, at http://hab.hrsa.gov/history/habpolicies.htm.

Permanency Planning: 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.

Referral to Health care and/or Supportive Services: The act of directing a client to a service in-person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff, or as part of an outreach program.

Transportation: Includes conveyance services provided, directly or through a voucher, to a client so that he or she may access health care or support services. May be provided routinely or on an emergency basis.

Other Support Services: Includes direct support services not listed above, such as translation and interpretation services.

Program Support: Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service-delivery patterns.

APPENDIX B

709C.1 Criminal transmission of human immunodeficiency virus.

1. A person commits criminal transmission of the human immunodeficiency virus if the person, knowing that the person's human immunodeficiency virus status is positive, does any of the following:

   a) Engages in intimate contact with another person.
   b) Transfers, donates, or provides the person's blood, tissue, semen, organs, or other potentially infectious bodily fluids for transfusion, transplantation, insemination, or other administration to another person.
   c) Dispenses, delivers, exchanges, sells, or in any other way transfers to another person any nonsterile intravenous or intramuscular drug paraphernalia previously used by the person infected with the human immunodeficiency virus.

2. For the purposes of this section:

   a) *"Human immunodeficiency virus"* means the human immunodeficiency virus identified as the causative agent of acquired immune deficiency syndrome.
   b) *"Intimate contact"* means the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus.
   c) *"Intravenous or intramuscular drug paraphernalia"* means any equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into or withdrawing a bodily fluid from the human body.

3. Criminal transmission of the human immunodeficiency virus is a class "B" felony.

4. This section shall not be construed to require that an infection with the human immunodeficiency virus has occurred for a person to have committed criminal transmission of the human immunodeficiency virus.

5. It is an affirmative defense that the person exposed to the human immunodeficiency virus knew that the infected person had a positive human immunodeficiency virus status at the time of the action of exposure, knew that the action of exposure could result in transmission of the human immunodeficiency virus, and consented to the action of exposure with that knowledge.

For all HIV applicable laws in Iowa, go to http://www.legis.state.ia.us/IowaLaw.html.