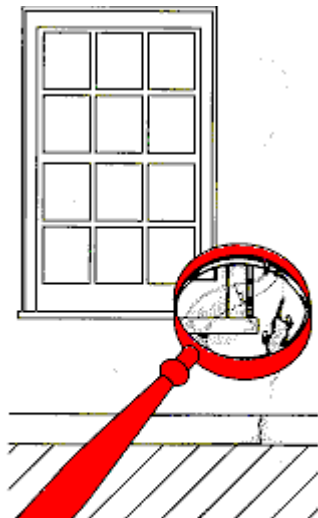




**State of Rhode Island
Department of Human Services
Center for Child and Family Health**

Comprehensive Lead Centers
Certification Standards

November 2006



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1.0 SERVICE INFORMATION AND BACKGROUND

1.1 Introduction

The Rhode Island Department of Human Services (DHS) has established a process for allowing qualified organizations to become Certified Lead Centers (CLC) to provide certain services to Medicaid eligible children who have been lead poisoned.

These certification standards serve to provide potential applicants, service providers, families and other interested parties with a full description of Certified Lead Centers, including guidance as to certification requirements and methods for application. Sections 1 through 5 contain service description and background as follows:

Section 1:	Service Information and Background
Section 2:	Certification Process
Section 3:	Background and Rationale for Development of this Service
Section 4:	Target Population
Section 5:	Service Description – Required Scope of Services

Section 1 provides a brief introduction to the service, Section 2 describes the process for certification and Section 3 contains a brief statement of the need for the service and the processes leading to development of these standards. Section 4 identifies the group of children this service is expected to benefit. Section 5, Service Description, contains a detailed description of the service and identifies core requirements for the service.

The Certification Standards include additional sections as follows:

Section 6:	Requirements for Organization of Service Delivery – Performance Standards
Section 7:	Qualified Entity Requirements

Sections 6 and Section 7 specifically describe the requirements for certification. Satisfactory compliance with these requirements must be demonstrated for certification; continuing compliance is required in order to maintain certification.

Certification applications will be primarily focused on Section 6. Although certified entities must comply with the requirements set forth in Section 7, the requirement to demonstrate such compliance in the application itself is more limited. The Application Guide (*Appendix A*) provides more detailed instruction as to how to develop the certification application.

Sections 8 through 11 cover a variety of administrative requirements.

1.2 Commitment to Family Centered Care

The Rhode Island Department of Human Services, Center for Child and Family Health, seeks to incorporate key elements of family centered, community based care into practice. Certified Lead Centers are expected to develop practices and programs consistent with the principles of family centered care. Core practices of family centered care include:

- Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service system and support personnel within this system fluctuate.
- Providing individualized services in accordance with the unique needs and potential of each child and guided by a child and family specific care plan that recognizes health, emotional, social and educational needs.
- Facilitating family/professional collaboration at all levels of hospital, home, and community care:
 - care of an individual child;
 - program development, implementation, evaluation, and evolution; and
 - policy formation.
- Exchanging complete and unbiased information between families and professionals in a supportive manner at all times and within the parameters of confidentiality.
- Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.
- Ensuring services are provided in the least restrictive, most normative environment that is clinically appropriate.
- Recognizing and respecting different methods of coping present in families and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental and financial supports to meet the diverse needs of families.
- Encouraging and facilitating family-to-family support and networking.
- Ensuring that hospital, home and community service and support systems for

children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.

- Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.
- Ensuring services that enable smooth transitions among service systems and natural supports that are appropriate to developmental stages of the child and family.

2.0 CERTIFICATION PROCESS

2.1 Submission of Certification Application Required

To be eligible to receive reimbursement for Lead Center services the provider must be certified by DHS as a Lead Center.

Applications will be evaluated on the basis of written materials submitted to DHS and related pertinent information. DHS reserves the right to conduct an on-site review and to otherwise seek additional clarifications prior to final scoring. DHS reserves the right to limit the number of certified lead centers in a particular geographic area, in order to ensure a sufficient volume of clients at each certified lead center.

2.2 Instructions and Notifications to Applicants

This document stipulates the certification standards for Lead Centers. These certifications standards also serve as the application guide. *Appendix A, Application Guide for Certified Lead Centers*, of this document identifies the standards against which applicants will be evaluated.

Within each area, specific standards and expectations are identified. Applications will be scored on the basis of responses to each of these specific standards and expectations.

Applications are to address each of these areas in the sequence presented. An Application Guide is presented in Appendix A to guide the organization of application materials.

Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these certification standards will be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

Interested parties are encouraged to contact CCFH for further information and clarification. Letters of Interest are strongly encouraged to ensure that DHS is able to keep interested parties up to date regarding scheduled meetings or program clarifications that may be needed. Inquiries and completed applications should be directed to:

Sharon M. Kernan, RN, MPH
Assistant Administrator, Child and Family Services
Center for Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920
Phone: (401) 462-3392

Once a provider is certified to provide Lead Center services, the provider shall be enrolled with EDS as a provider of these services. Questions about the enrollment form or enrollment process should be directed to EDS at 1 (800) 964-6211.

2.3 Certification and Certification Period

Initial certification will be granted for up to a three-year period. DHS reserves the right to certify one or more applicants (*See Appendix A.*)

Certification requires that providers adhere to identified standards and provide periodic reports (See Section 6) to DHS. These certification standards include certain performance standards. Certified Lead Centers are required to notify DHS in the event of any material changes in their organizational circumstances or program operations. DHS will monitor the performance of certified Lead Centers and their continued compliance with certification requirements and performance levels. On the basis of its review and at its sole discretion DHS reserves the right to identify deficiencies in performance and/or compliance with certification requirements.

Certification may be modified to provisional or probationary certification or terminated, for failure to comply with DHS requirements.

3. BACKGROUND AND RATIONALE FOR DEVELOPMENT OF LEAD CENTERS

3.1 Background

The Rhode Island Department of Human Services (DHS) has developed and funds a lead poisoning prevention, case management and environmental intervention program, targeting Medicaid eligible children, to be implemented through payments to certified vendors for a specified set of services.

Many Rhode Island children are exposed to environmental conditions that result in elevated blood lead levels (BLL's), which have an adverse effect on growth and development. The State has already undertaken substantial work in identifying children with elevated blood lead levels. The next step is to implement a program that will effectively ameliorate the existing lead poisoning and prevent new exposures. The RI Department of Health has developed childhood lead poisoning definitions, as follows:

- For RI Department of Health surveillance purposes, any child under the age of six with a blood lead level (BLL) of greater than or equal to ten (10) micrograms of lead per deciliter of whole blood (≥ 10 $\mu\text{g}/\text{dL}$).
- An Elevated Lead Level is defined as one venous BLL between 15-19 $\mu\text{g}/\text{dL}$. If the child's BLL result is from a capillary screening, the RI Department of Health sends a letter to the Primary Care Provider recommending a confirming venous test.
- 'Significant childhood lead poisoning' is defined as one venous BLL ≥ 20 $\mu\text{g}/\text{dL}$ in a child under six years of age or two (2) BLL's (capillary or venous) ≥ 15 $\mu\text{g}/\text{dL}$ done 90-365 days apart. Two BLL's (capillary or venous) ≥ 15 $\mu\text{g}/\text{dL}$ may be referred to as 'persistent' lead poisoning. For more information, refer to the State of Rhode Island Department of Health Rules and Regulations for Lead Poisoning Prevention (RI General Laws Title 23, Chapter 24.6-PB) as amended January 2005.

The Department of Human Services makes Lead Center Services available to Medicaid-eligible families with a lead poisoned child with a single venous BLL ≥ 15 $\mu\text{g}/\text{dL}$ in a child under six years of age. For eligible children enrolled in a RIte Care Health Plan (Neighborhood Health Plan, United Healthcare RIte Care, or Blue Cross RIte Care), Medicaid covers window replacement and spot repair/removal services.

Lead poisoning is a multi-faceted problem that must be addressed through a coordinated spectrum of services designed to be family/home-oriented, and managed on a case-by-case basis. DHS, in cooperation with the Department of Health (DOH) has established a program, Certified Lead Centers (CLC), which is designed to provide an array of services that focus on lead education, case management and environmental issues, particularly housing. Certified vendors will work closely with families to provide intensive case management; family education; intensive cleaning technique training; referrals to medical, legal, nutritional, Early Intervention, Special Education, Head Start, Comprehensive Child Care Services, CEDARR Family Centers (Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-Evaluation) and other program-based services; temporary lead hazard control and lead reduction services including intensive environmental cleaning, window replacement and spot removal, and assistance with relocation services as needed.

4.0 TARGET POPULATION

4.1 Eligibility

All Medicaid eligible children (including children in RIte Care and RIte Share) and their families are eligible to receive Lead Center services. Only RIte Care/RIte Share-enrolled children are eligible to receive Medicaid funding for window replacement and spot repair/removal services. Eligible families are those with a child with a BLL \geq 15 $\mu\text{g}/\text{dL}$.

4.2 Choice of Provider & Acceptance of Services

All Medicaid families have the right to choose from which lead center they wish to receive services. Accordingly, each lead center will obtain a signed acceptance form at the initial visit in which the family agrees to accept services from the lead center of choice. (See *Appendix B – Acceptance of CLC Services and Lead Center Choice Form*)

5. SERVICE DESCRIPTION - REQUIRED SCOPE OF SERVICES

5.1 Service Name and Definition: Scope of Services

Certified Lead Centers must be able to provide three core services. These include:

- A.** Case Management and Education: Includes assessing the child's risk factors for continued lead poisoning as recommended in the RI Department of Health's Lead Screening and Referral Guidelines (www.health.ri.gov/lead/family/leadposter.pdf) educating the family on lead poisoning and nutritional counseling (and referral to WIC and Food Stamps), and ensuring the lead poisoned child receives all necessary services, including medical visits, and developmental screening (using a standardized developmental screening tool.)
- B.** Housing Advocacy and Support: Includes reinforcing lead education for temporary lead hazard control measures (i.e.: wet cleaning of horizontal surfaces, HEPA vac use, duct taping and blocking access to lead exposure hazards), referring families to lead hazard reduction resources, providing housing advocacy (i.e.: assistance in relocation, support in landlord negotiations, assistance in scheduling and completion of housing inspections upon request and reviewing housing inspection reports, and supporting families in court appearances, as needed.)
- C.** Window Replacement and Spot Removal Services: Includes arranging for or providing window replacement and associated spot removal services, in conformance with DOH Rules and Regulations for Lead Poisoning Prevention. Please refer to:
<http://www.rules.state.ri.us/rules.released/pdf/DOH/DOH 3357.pdf>

Certified Lead Centers must provide all three of these core services, with the following contracting provision. Window Replacement and Spot Removal Services may be provided by CLC qualified staff, a qualified sub-contractor, or through a partnership agreement, in which the CLC presents in its application a community partner to provide the window replacement and spot removal services. This partnership must be a contractual relationship with the CLC and must be pre-approved by DHS. DHS will separately certify the partner agency as a Medicaid provider limited to these services. DHS will prior authorize all window replacement and spot removal services and directly reimburse the certified partner directly when these authorized services are provided.

Certified lead centers must also work with the RI Department of Health's Childhood Lead Poisoning Prevention Program and use their "Case Management Protocols" which contain specific details about the referral process, responsibilities of the lead centers, protocols, outcome measures, and the use of quality assurance, among others. Additionally, lead centers are asked to sign a Memorandum of Understanding with the RI Department of Health that will delineate the terms under which both parties will establish a cooperative relationship. More information on these documents is available by contacting the Lead Program at the Department of Health, at (401) 222-2310.

5.2 Case Management and Education – Core Service

NOTE: Additional guidance on several of the core services described in this section is available in the RI Department of Health "Case Management Protocols."

The primary function of the Comprehensive Lead Center (CLC) is case management. The most important goals of case management are to reduce the child's exposure to lead and to empower the family toward effective self-care. Case management is comprised of engagement, assessment and diagnosis, service planning and resource identification, linkage to needed services, service implementation and coordination, monitoring of service delivery, advocacy and evaluation. The successful applicant will be responsible for the overall case management of those children and families identified as being eligible for services. CLCs will work with the families, medical personnel, and other programs to ensure that the targeted children receive the appropriate services in the proper amount and duration to best address their level of need. This case management program must be coordinated with other case management programs involving the child or family.

As it begins case management, the CLC will provide education and educational materials to the family and to providers when needed, and will work closely with DOH and other stakeholders on all educational activities. The various parts of the educational process will address: lead poisoning prevention and risk reduction; hand and toy (and other object) washing; nutrition; environmental control; effective home cleaning; and keeping the child lead-safe in outdoor and out-of-home settings.

The CLC services for case management and education must include the following required components: comprehensive needs assessment, the Family Care Plan (which

incorporates a lead hazard control and/or reduction action plan, a housing plan, and in preparation for case closure, a discharge/aftercare plan), nutritional counseling, non-medical case management and coordination of non-medical services with medical care and developmental assessments and follow-up services. (See *Appendix C, Certified Lead Centers (CLC) Services, Service Description and Criteria for Lead Poisoned Children with BLLS \geq 15 μ g/dL*)

5.2.1 Comprehensive Needs Assessment

The CLC is responsible for an initial and ongoing comprehensive needs assessment of the lead poisoned child, including the environment and family.

5.2.2 Family Care Plan

The Family Care Plan (FCP) is the core plan that guides the level of care and the intensity of services to be provided to both the subject child and the family. The FCP is a written document developed in coordination with the family, and addresses all services to be provided and coordinated through the CLC.

The CLC must contact the DHS caseworker if the family is in the Family Independence Program (FIP). The FCP must be complementary to the FIP Work Plan. It is recommended that the CLC collaborate with the DHS caseworker while developing the initial FCP and thereafter with updates. The CLC should send a copy of the FCP to the Primary Care Physician (PCP) and to the DHS caseworker. The FCP focuses not just on the child, but on the family as a whole. This may include a foster family, an extended family, or other caregivers for the child. The FCP must ensure that screening for lead poisoning is up to date for all other children in the family. The Family Care Plan should include the PCP's plan for BLL retesting and, if appropriate, referral to a Lead Clinic. Since the most important factor in case management is to reduce the child's exposure to lead, the CLC should have a Lead Hazard Reduction Action Plan. This plan can be incorporated within the FCP or can be a separate plan, serving as a problem resolution checklist (See *Appendix D, Lead Hazard Reduction Action Checklist*.) In addition, each FCP must address relevant housing issues, with a goal to ensure the child resides in a lead-safe environment. The CLC and FOP will follow mutually agreed upon protocols for timely sharing of relevant case information to develop or modify the FCP, including copies, as appropriate.

The CLC must identify a specific case manager for each child or family. This individual is responsible for all communication and coordination with the child's PCP or treating physician, all treatment providers and community support agencies and the child's Health Plan, when appropriate. (See *Appendix E, Sample Letters for Communication with Family and Child's PCP or Treating Physician*.) Additionally, the case manager works with DHS and DOH as necessary. This individual will serve as the single point of contact for the child, family, and all providers and agencies. Each family's initial education plan and all subsequent revisions should be in the FCP, with copies to the family, the child's PCP and/or the lead treatment provider.

The FCP includes the planning, monitoring, and tracking for all referrals to ancillary services that may be identified through the assessment process or any other additional screening or treatment the child undergoes. Such referrals or services may be medical, developmental, nutritional, environmental or legal in nature, including referrals to DCYF as appropriate and may include referrals for other siblings in the family. (See *Appendix F*, Sample Referral Letter)

The FCP is intended to be a living document, which grows and changes, reflecting a current appraisal of the child's status, while documenting changes. Feedback from the servicing providers and agencies and updates to the FCP should be ongoing. The CLC should inform the PCP when it opens a case, should send a copy of the FCP to the PCP, and inform the PCP when a case is closed, including a summary of services provided and alerting the PCP to any outstanding concerns or issues.

5.2.3 Nutritional Counseling for Lead Poisoned Children

In addition to removing or controlling the sources of lead exposure from the environment of children with lead poisoning, nutrition counseling is an essential, priority component of the action plan to reduce the absorption of ingested lead and its harmful effects. Nutrition counseling should emphasize the following key elements:

- Diets low in fat, and high in iron, calcium and total calories, are associated with decreased risk for lead absorption
- Optimal intake of foods rich in the following nutrients (with examples) should be encouraged:
 - Calcium (dairy products)
 - Fiber (including whole grain breads and fortified/whole grain cereals)
 - Iron (red meat, iron fortified cereal)
 - Protein (chicken, meat, fish and dairy products, nuts and legumes)
 - Vitamins C and D (citrus fruits and fortified milk)
 - Zinc (variety of fruits and vegetables)
- Regular meals and well-spaced nutritious snacks (at three hour intervals) are important in preventing or reducing the absorption of lead in children
- Thorough hand washing with soap and running water is a must before all meals and snacks

- Other techniques to prevent environmental lead contamination of food (i.e.: A child should sit to eat; caretakers should discourage “cruising” walking around while eating)

Optimal nutrition is an essential tool for reducing elevated BLLs and preventing re-poisoning. Nutritional counseling should be specifically tailored to each family with attention to the family’s cultural background and financial situation. All lead poisoned RIte Care/RIte Share-enrolled children are eligible for WIC. Families should be encouraged to enroll in WIC for free supplemental nutrition and to keep WIC appointments. PCP’s may also refer families to a licensed dietician/nutritionist, as appropriate (See *Appendix G, Nutrition Referral Criteria for Children who are Malnourished, Anemic or Lead Poisoned.*) Families should also be encouraged to apply for and use Food Stamps, as appropriate.

5.2.4 Non-Medical Case Management

Non-medical case management covers all of the other services that a lead poisoned child or family might need outside of direct medical care. This includes, but is not limited to, oversight and monitoring of the FCP implementation; monitoring family participation in achieving a lead-safe environment; facilitating timely access to and provision of services; facilitating transportation and interpretation services, as necessary; coordinating resources of the various agencies involved in the child’s care; locating and providing available information and other information resources for the family; referring to needed services for social and financial issues and assistance; as well as referrals to various programs and state agencies such as:

- Family support groups
- Community action programs
- Domestic violence programs
- Legal services (such as R.I. Legal Services)
- Project Connect
- Substance abuse treatment
- Travelers Aid
- Housing-related programs (see list in Section 5.3.4)
- Other agencies or programs, as appropriate

5.2.5 Coordination of Non-Medical Services with Medical Care

Responsibility for the provision of medical services and medical case management remains with the PCP, Lead Clinic and/or attending physician at all times. The CLC has responsibility to coordinate all non-medical services with this medical care. The CLC will participate in case conferences when necessary and appropriate. The CLC should inform the PCP or attending physician of any relevant information or substantial developments that might assist in providing appropriate medical care to the client and family.

5.2.6 Developmental Screening

Developmental screening using an agreed-upon tool should be completed on all lead poisoned children within 30 days of referral, to facilitate immediate access to necessary services and referrals. A copy of completed developmental screening should be forwarded to the PCP and/or the attending physician. Based upon screening results, children should be referred to programs such as Early Intervention, Head Start, Early Start, Special Education and the Comprehensive Child Care Services Program.

5.3 Housing Advocacy and Support - Core Service

5.3.1 Visual Environmental Lead Assessment for Family Lead Education

As part of its initial contact with the family, the CLC should perform a Visual Environmental Lead Assessment of the child's home and all other environments where the child stays or plays. (See *Appendix H*, Visual Environmental Lead Assessment Report.) The purpose of this assessment is to guide the temporary lead hazard control measures by identifying the potential sources of lead poisoning in the environments where the child lives, stays or plays. In some instances, more than one location may need to be assessed, such as the child's day care setting.

It should be understood that the Visual Environmental Lead Assessment does not definitively determine sources of lead in the child's environment, but rather provides an opportunity to identify potential lead sources based upon the age of housing, the general appearance and status of the integrity of painted surfaces and age/condition of windows, areas of potential friction/friability of painted surfaces and/or indication or likelihood of paint dust as well as the presence of 'tracked in' material from the outdoors. Other potential lead sources such as high-risk occupations and hobbies of household members should also be assessed by the CLC. This assessment will provide the basis for family lead education.

5.3.2 Provision of Lead Education

The CLC will provide education and educational materials to the family and to providers when needed, and will work closely with DOH on all educational activities. The various parts of the educational process will address: lead poisoning prevention and risk reduction; hand and toy (and other object) washing; demonstration of home cleaning methods and fostering the family value of the importance of cleaning; environmental control; keeping the child safe from lead in outdoor and out-of-home settings; and assisting in finding lead safe housing (both temporary and permanent) as appropriate. Services encompass Visual Environmental Lead Assessment, abatement advocacy and monitoring of the environment, as needed. The CLC will be responsible for providing direct focused education to families and other childcare providers, as frequently as necessary, through:

- “Hands on wet cleaning techniques training to the families of children under its management for lead poisoning in the home. Lead education should be a customized, “common sense approach for families to maintain a lead-safe environment. The CLC program will encompass verbal, written/pictorial and actual physical demonstration of wet cleaning techniques. The use of training and educational materials will be guided by the family’s cultural and literacy level requirements. The primary focus of this training program will be the family, but the training program may also need to be provided to the PCP for reinforcement by the PCP to the family. The CLC will also provide education on the proper use of the HEPA vac for families who need to use this piece of equipment.
- Based on the family’s needs, in-home education will include all types of washing and home cleaning methods as temporary lead hazard control measures; environmental control both within and outside of the home; and other applicable lead poisoning prevention activities. The CLC will provide specifics to the families about recommended actions and about homeowner and landlord responsibilities to reduce or eliminate sources of lead hazards in and around the home, as appropriate. Lead education should be designed to empower the family toward effective self-care that is sustainable and that can be generalized to other environments beyond the current home setting.
- Educational information to families about the environmental lead hazard reduction process, as appropriate, including issues to be aware of during contractor abatement work.
- Participating in DOH review committees in the development of educational strategies and materials
- Ensuring that interested and/or involved parties (i.e.: providers, community agencies and Health Plans) are educated about relevant lead issues:
 - Distribute educational materials in coordination with DOH and other community agencies
 - Collaborate with the RIte Care Health Plans to ensure that lead education and educational materials are provided to the PCPs and other appropriate medical service providers

5.3.3 DOH Comprehensive Environmental Lead Inspection and CLC Work Specification Review and Clearance Inspection

As previously stated, the CLC is responsible for reviewing the potential problem areas identified from the Visual Environmental Lead Assessment and ensuring the family understands the necessary recommended temporary lead hazard control measures (i.e.: restricted access, use of duct tape and wet cleaning of horizontal surfaces.)

The DOH is responsible for and oversees the Comprehensive Environmental Inspection process for families with a significantly lead poisoned child BLL > 20 µg/dL or persistent > 15 µg/dL. This inspection must be conducted by a DOH-licensed Environmental Lead Inspector/Inspector Technician in accordance with state regulations.

Upon request of the inspector, the CLC will assist in scheduling and actual completion of this inspection. The CLC is also responsible for assisting (with the inspector) in educating the family on the findings and recommendations in the DOH Comprehensive Environmental Inspection Report. The DOH is responsible for the contact and education of landlords/owners for these cases.

Families with a child under six years of age (with a single venous BLL \geq 15-19 µg/dL) are not eligible to receive the DOH Comprehensive Environmental Inspection. If the results of the Visual Environmental Lead Assessment conducted by the CLC indicate a possible need for window replacement and/or spot repair/removal, the CLC will ensure that a licensed inspector or inspector technician conducts a “Work Specification Review” to determine how many windows need to be replaced and what level of spot repair is needed. This report (if it confirms window replacement and/or spot removal are needed) will provide the level of detail needed to develop a “work order” for window replacement and/or spot repair. (Refer to *Appendix I* for an example of such a “Work Specification Review.”)

The CLC is responsible for educating the family and the landlord/owner on the findings and recommendations in the “Work Specification Review.” This review will provide guidance for window replacement and/or spot removal.

The Lead Center is responsible for ensuring a “Clearance Inspection” is done when window replacement and/or spot repair services have been provided, for children not eligible for the DOH Comprehensive Environmental Lead Inspection.

The CLC may not offer or provide a “Work Specification Review” for housing units of children eligible for the DOH Comprehensive Environmental Lead Inspection.

The Lead Center is responsible for conducting a “Clearance Inspection” when window replacement and/or spot repair services have been provided.

5.3.4 Housing Relocation Assistance - Referrals for Housing and Legal Services

The CLC will provide individualized and family specific assistance to families that need to relocate due to lead poisoning. The CLC coordinator will assist in finding and directing the family to the proper agencies which can further assist them in finding the necessary housing to meet specific needs. The CLC will also provide guidance to families seeking legal information and resources, and will act as an advocate for the implementation of lead-safe housing. The CLC will assist the family in finding transitional or permanent housing when it has been determined that the child cannot return to his/her previous housing.

- For any family about to move, the CLC will:
 - Provide assistance to the family in finding lead-safe housing, including support in how to determine a housing budget, what programs are available to assist with rental payments, rights and responsibilities regarding rent payments and deposits at the current residence, rights regarding retaliatory eviction, how to discuss the need for lead-safe housing with a prospective landlord, and what to look for (and look out for) in a new housing unit
 - Assist in locating transitional housing, while the family is awaiting or seeking permanent lead-safe housing
 - Assist in finding permanent housing
 - Coordinate with DHS Housing Service workers (located in DHS Field Offices) to ensure that DHS Housing Service workers conduct a Visual Environmental Lead Assessment for potential lead hazards during property inspections prior to providing DHS financial support for families to move

The CLC is also responsible for additional referrals to address family-specific housing related issues, to organizations and agencies, including but not limited to:

- Housing and Urban Development (HUD) Loan Program
- Legal services (such as R.I. Legal Services)
- Municipal Minimum Housing (Code Enforcement) Officials
- Providence Housing
- R.I. Department of Health Lead Program
- R.I. State Emergency Rental Assistance Program
- R.I. Housing Rental Assistance
- R.I. State Weatherization Program
- R.I. Housing and Mortgage Finance Corporation
- Section 8 Public Housing
- Shelters
- Travelers Aid
- Local city/town lead abatement programs and/or funding, when available

5.4 Intensive Environmental Control: Intensive Cleaning, Window Replacement/ Refurbishment and Spot Removal

The establishment of a lead safe home environment for children is critical. The CLC can provide two critical services to help assure a lead safe home environment; these services are Intensive Environmental Cleaning Services and Window Replacement/Refurbishment, and spot removal. As a last resort, family relocation may be the most appropriate option to help provide lead-safe housing for families with eligible children who have been lead poisoned.

A. Intensive Environmental Cleaning Services

Most families will be able to perform this intensive cleaning themselves, with appropriate instruction and support from the CLC. The CLC is responsible for providing this service when families are unable to perform this service themselves. DHS expects the CLC to directly provide this service only in situations in which the family members are unable to perform this themselves due to cognitive limitations, physical disabilities or similar hardship situations. The CLC will determine if this service is needed, based on its Visual Environmental Assessment, the DOH Comprehensive Housing Inspection Report (when available) and the CLC's evaluation of the family's ability to perform the service.

- In the event that the necessary cleanup is so extensive and the family is unable to perform the proper level of cleanup, the CLC is responsible for providing and paying for intensive environmental cleaning services, either directly or through a sub-contractor.
- The CLC will facilitate the scheduling, access and any temporary housing, as necessary.
- If the CLC chooses not to provide this service directly, and delegates provision of this service, vendor identification and qualification will be made by the CLC, with final DHS approval. Qualified vendors must be in compliance with applicable DOH regulations.
- The reimbursement to the CLC for intensive environmental cleaning is built into the existing fee schedule and is not separately reimbursable.

B. Window Replacement/Refurbishment and Spot Removal

- This program is available for those houses needing window replacement or refurbishment. Prior approval by DHS is required for reimbursement of this service (See *Appendix J, Prior Authorization Form and Reimbursement Worksheet for Window Replacement and Spot Repair/Removal.*)
- The CLC will determine the need for window replacement/refurbishment based on the CLC Visual Environmental Lead Assessment, the Comprehensive Environmental Lead Inspection Report or the Work Specification Review, and the CLC's assessment of the family's situation, which should include, but is not limited to, the family's plans for moving and the general condition of the dwelling. (Window replacement is not appropriate if the family is intending to move or if the

dwelling is unfit for habitation or so unsound or out of building code compliance that it is likely to be or has been condemned, or for other documentable reasons.) The CLC will facilitate the scheduling, access and any temporary housing, as necessary.

- The CLC will provide the window replacement using either their own qualified staff, a qualified sub-contractor, or a DHS certified partner, as explained in Section 5.1 and in compliance with RI Rules and Regulations for Lead Poisoning Prevention. Window replacement/refurbishment can include repairs to, or replacement of structures surrounding windows, i.e. sills, framing, etc.
- In some cases, grants, loans and repayment programs may be available for certain needed abatement services. The CLC will be expected to be knowledgeable about all available programs and resources which could help property owners pay for needed abatement, and assist property owners in applying for these resources. In some cases, DHS funds will be used to pay for window replacement. The CLC will be required to assist DHS in placing a lien on the property, which receives window replacement, according to protocols developed by DHS. (See *Appendix K*, Template Letter and Lien Agreement). The CLC will be responsible for payment of any fees associated with the filing of these liens. These liens may be interest free at DHS's sole discretion. The CLC will ensure that the property owner signs two original copies of all lien documents; one set of originals is sent to the DHS CCFH Lead contact.
- All certified CLCs and DHS approved partners must be in compliance with applicable DOH regulations for lead hazard reduction activities as well as all other environmental interventions not requiring use of a Licensed Lead Hazard Reduction Contractor (i.e.: window replacement or spot removal.)
- Spot Removal is defined in the Lead Poisoning Prevention Regulations, Title 23, Chapter 24.6 of RIGL, as removal of interior lead-based paint, which is not considered lead hazard reduction when the amount of paint to be removed is less than the amount specified in subsection 11.1 (b) (1).

Note: This benefit is currently available only to children enrolled in RIte Care/RIte Share. Fee for service (FFS) Medicaid-eligible children not enrolled in the Department of Human Services 1115 waiver are not eligible to receive window replacement/refurbishment or spot removal service.

Family relocation is the last resort. When it becomes apparent that abatement will not occur in a timely manner, the CLC will assist in locating alternative permanent lead-safe

housing. The CLC will also assist in locating temporary housing for families whose home is undergoing lead abatement.

In all situations where extensive environmental control and abatement are the appropriate actions, the CLC will work with DOH and all available funding sources to ensure that any existing resources are used to establish lead-safe environments to the greatest extent possible. In some cases, funding sources such as grants, loans, and low-interest repayment programs may be available to pay for needed hazard reduction services. The CLC is expected to be knowledgeable about all programs and resources available to help property owners pay for needed abatement, and assist property owners in applying for these resources.

5.5 Family Involvement and Responsibility

Lead Center Services are home and community based services through which a family is provided critical supports and assistance in the care of a child who has been lead poisoned. These standards identify a series of requirements for certified providers. Lead Center providers must demonstrate understanding of and respect for the fact that they are entering into a private residence for the performance of specific duties in support of the child and family.

Similarly, providers can reasonably expect that families will recognize and respect the roles and responsibilities of providers. In order for Lead Center services to be effectively and safely provided, the family must be able to ensure that the care setting is safe and that family members will work positively with the provider in maintaining a collaborative relationship.

6.0 LEAD CENTER CERTIFICATION REQUIREMENTS

6.1 Services

Successful CLC applicants must demonstrate the ability to provide all of the required services either independently with employees, subcontractors, volunteers and/or with a partner.

6.2 Staffing

The CLC must also have (through its personnel) the proper levels of experience, training and cultural competency to serve the Medicaid population adequately.

- CLC applicants must demonstrate the capabilities to perform the required services for the anticipated volume of case management and the other required services. Staffing may be comprised of full time or part time staff or contracted consultants. Staff must have a working knowledge and understanding of the roles and responsibilities of State agencies in all areas of lead poisoning treatment and prevention. The CLC will include DOH policies and procedures for

Environmental Lead Inspections in its staff orientation and ongoing continuing education.

- The range of credentials required of the staff within the CLC (employees, contractors, or volunteers) include:
 - Experience to coordinate quality care and to case manage lead poisoned children.
 - Bi- or multi-lingual and cultural sensitivity
 - Supervisory staff with appropriate credentials and experience (i.e.: RN, MSW)
 - Individual(s) performing inspection, temporary hazard control activities, spot removal and window replacement services or other lead hazard control activities must comply with state regulation (and DOH-required licensure, as required)
- A successful CLC applicant will have written policies and procedures in place to hire and train individuals who are participating in the Family Independence Program (FIP). The CLC must have stated goals relative to hiring and training individuals in FIP and report progress toward these goals to DHS upon request.

6.3 Financial Resources

Lead Center applicants must be able to demonstrate adequate financial resources to allow for development and implementation of the required services and for organizational sustainability.

6.4 Management and Organization

Lead Center applicants must provide, for review, a management and organizational structure that will establish the proper control and direction for the organization to adequately implement and operate the required services and programs.

The CLC must have/develop operational policies and protocols for its activities. These policies and procedures should be reviewed at least annually and be approved by the Board of Directors.

6.5 Availability and Response Times

Successful CLC applicants must be capable of meeting the following requirements:

- Substantial extended hours encompassing early mornings, evenings and weekends as well as normal business hours, as needed to ensure that families served by the CLC are able to access the services provided in

a timely manner. The CLC will ensure that its hours of operation are convenient and accessible for both working and non-working families.

- Urgent situations (e.g. a hospitalized child) must be responded to as soon as possible or within a maximum of 24 hours. This capacity must be available seven days a week, 365 days per year.
- Telephone response times (for return telephone calls) to physicians, families and other providers and agencies or programs must be within one business day (24 hours).
- A case manager must be available to make a home visit on a new case within 72 hours.
- Home visits must be scheduled within the following timeframes:

BLL	single	15-19 µg/dL	10 days
BLL	persistent	15-19 µg/dL	5 days
BLL		20-44 µg/dL	5 days
BLL		45-70 µg/dL	24 hours
	Hospitalized Child		24 hours

6.6 Satellite Sites

Lead Centers wishing to establish any satellite sites must submit a separate application to DHS for any such satellites. Satellites must be in compliance with all the specifications in this document.

6.7 Quality Improvement Program

CLC's shall have a written, ongoing program of Quality Improvement. The CLC may initiate quality improvement project(s) individually or in collaboration with other CLC's.

Each CLC must participate in annual Quality Improvement projects developed in collaboration with the RI Department of Human Services and RI Department of Health, and be prepared to report results.

6.8 Grievance and Appeals Program

The CLC must have a fully functioning grievance program in place at the time of approval. The grievance program must include the reporting of information back to the Center for Child and Family Health at DHS. *(See Appendices L-Q, Requirements for Lead Center Grievance and Appeal Program, Lead Center Informal Complaint Summary, Lead Center Grievance and Appeals Log, Lead Center Guide to Complaints, Grievance and Appeals, Rhode Island Department of Human Services Request for Hearing Form (DHS-121), Rhode Island Department of Human Services Information*

About Hearings for Applicants and Recipients of Financial Assistance, Food Stamps, Medical Assistance and Social Services.)

The Certified Lead Center agrees to submit an annual grievance and appeals report that conforms to the State's specifications. This report is due no later than thirty (30) days after the end of the reporting year.

6.9 Record Keeping and Reporting Systems

Lead centers must be in compliance with all requirements of HIPPA. Lead centers must keep case files for a minimum of 10 years after case closure. Additionally, CLC's must report suspected instances of child abuse and neglect to DCYF, as required by Rhode Island state law.

6.9.1 Financial Reporting

The success of the CLC is contingent on its financial stability. As part of its oversight activities, the State will establish financial viability criteria, or benchmarks, to be used in measuring and tracking the fiscal status of the CLC. The areas in which financial benchmarks may be established include the following:

- Balance Sheet Activity
- Cash Flow-Liquidity
- Profitability
- Aging of Receivables
- Operating Budget (YTD)
- Annual Audit with Management Report
- Statement(s) of Intent for off-budget contributions

CLC agrees to provide the information necessary for calculating benchmark levels (see the following section). CLC also agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks. Upon request, the CLC will provide financial reports including balance sheet, income, and cash flow statements. Upon request, the CLC will provide copies of financial reports presented to its Board of Directors and the annual audited financial statements and management reports within 10 business days.

6.9.2 Reporting Responsibilities

The CLC is responsible for providing reports as specified in this document.

6.9.3 Closed Case Summary Report

This reporting must be on a case-by-case basis and must be submitted electronically to DOH. A copy must be sent to the PCP within 10 business days following the month in which the case was closed. (DHS does not need to receive this reporting, but may request case specific reporting or review reporting as part of its monitoring and oversight

responsibilities.) Summary reports of CLC closed case reports will be prepared by DOH and will be discussed at CLC meetings.

7.0 REIMBURSEMENT

Refer to *Appendix R* for rates of reimbursement, effective May 1, 2006.

7.1 Window Replacement/Refurbishment

Reimbursement for window replacement/refurbishment and spot removal will be at an established rate, based on the authorized work performed including spot removal and the number of windows involved. DHS will preauthorize this service. (*See Appendix J, Prior Authorization Form and Reimbursement Worksheet for Window Replacement and Spot Repair/Removal.*)

7.2 Intensive Cleaning

Intensive cleaning is the responsibility of the CLC. There is no additional reimbursement for intensive cleaning services.

8.0 CERTIFICATION AND RECERTIFICATION

8.1 Initial Certification

The initial certification approval must occur prior to the applicant performing any services under the program. The process is comprised of two steps:

- Submission of a letter of application with a qualifications statement by the applicant, including the following areas:
 - Staffing, Availability, Capacity and Response Times
 - Ability to Provide Services
 - Management and Organization
 - Financial Resources
 - Outreach Program
 - Quality Improvement Program
 - Record Keeping and Reporting System Abilities
- Evaluation of qualification areas by DHS with input from DOH, with written notification of approval or denial of certification

8.2 Recertification

The recertification review is performed by DHS, at a frequency to be determined, as follows:

- Certification Standards Compliance Evaluation (including CLC Report Results)

- Financial Performance Evaluation
- Operational/Organizational Review
- Quality Improvement Performance Evaluation

9.0 REQUIREMENTS FOR ORGANIZATION OF SERVICE DELIVERY

An applicant for certification must demonstrate that it brings to the program a sound combination of case management skills and experience, and the capability to reliably provide needed services.

There are specific certification requirements that must be addressed in a certification application. Applicants are to describe their approach to meeting these requirements. Further guidance as to how to complete the application is included in the Application Guide (Appendix A.)

9.1 Agreement to Accept all Medicaid Referrals, Provide Authorized Services

Certified Lead Center providers will be expected to accept all appropriate referrals of Medicaid enrolled children determined to be eligible for Lead Center services and to provide services on a timely basis as detailed in Section 6.5 of these standards.

9.2 Clinical Roles and Scope of Practice

The work of the Lead Center team must be systematically organized with a clear delineation of staff roles, reporting relationships and supervision. Job titles must be identified. An organization chart is to be included. Protocols will include clear delineation of the role and scope of practice of each position within the treatment team. The respective roles of team members, based on the team supervisory structure and the licensure/certification of each team members needs to be clearly defined. Clear descriptions of the role of each team member is needed in such areas as:

- Title, position description and qualifications
- Supervision, scope of practice, and authority
- Treatment Plan design, monitoring, modification and evaluation
- Coordination with family
- Accountability

9.3 Staff Training and Orientation

Certified providers will have a comprehensive orientation program for all employees consistent with the certification/licensure requirements of each position. The orientation program will reflect a family centered approach to care and will include an assessment and skills inventory appropriate to each classification prior to orientation and assignment to families.

Providers will have an organized and defined continuing education/training program or requirement to ensure that the competencies and relevant knowledge are maintained and developed.

All staff providing direct services must be at least eighteen (18) years of age and must satisfactorily pass a criminal background clearance.

The CLC will include DOH policies and procedures, including those for Environmental Lead Inspections, in its staff orientation and ongoing continuing education. Documentation must be in employee's personnel file.

9.4 Service Monitoring

Certified Lead Centers will maintain a management information system which will enable it to effectively monitor and manage its services. State reporting requirements are established to track routine compliance with certification standards and should relate to elements of operations.

9.5 Record Keeping Requirements

The agency must describe its policies and procedures for record keeping. The agency must ensure family access to the clinical record and must ensure that patient confidentiality is maintained. Additionally, the agency must provide long-term storage of clinical records in accordance with Medicaid regulations, which require that clinical records be kept for ten (10) years.

10.0 QUALIFIED ENTITY

A certified provider must be able to demonstrate that it complies with core state requirements as to organizational structure and process. These requirements pertain to areas such as incorporation, management of administrative and financial systems, human resource management, information management, quality assurance/performance improvement and others. State requirements in these areas are consistent with the types of expectations or standards which would be set forth and surveyed by health care accrediting bodies and which are generally held to be critical to effective, consistent, high quality organizational performance and care provision.

Applicants for certification are not required to systematically address in detail each of these areas in their certification applications. Rather these are set forth as fundamental requirements for certified entities. In most areas applicants will be asked to provide assurances that their agency systematically addresses each of the standards identified. In certain areas, more specific description regarding the manner in which the agency meets the standard is required. The Application Guide (*Appendix A*) provides guidance as to how the application should be structured and the areas that need to be addressed.

In not requiring applicants to explicitly address the elements in Section 10, the State is seeking to simplify the effort needed to develop an application; these certification requirements remain in place. The State reserves the right to review certified entities for compliance with these certification requirements.

10.1 Incorporation and Accountable Entity

The applicant for certification as a Lead Center provider must be legally incorporated. The certified entity shall serve as the accountable entity responsible for meeting all of the terms and conditions of a certified Lead Center. Applicants must clearly present the overall structure by which services, requirements and programmatic goals will be met. The corporate structure of the entity must be clearly delineated.

10.1.1 Partnership Option

Satisfactory performance as a certified Lead Center calls for significant organizational capability. In some cases this capability may be present within a single organization and application for certification will be made based on the strengths of that single organization. In other cases the application may represent two entities in partnership, which together have the combined capabilities to meet the certification requirements. The application must make it clear whether the applicant is seeking certification to provide all of the core services directly or only designated core services, with window replacement and lead hazard reduction services provided through a partner. See Section 5.1 for delineation of this.

10.2 Governance and Mission

The governance of the entity must be clearly delineated. Composition of the Board of Directors and any conditions for membership must be clear. The overall performance of an organization flows from the philosophy and oversight of the leadership. Leadership and stakeholders “build” the mission, vision and goals; this in turn shapes the business behavior and is reflected in the tone that leadership sets for the operation of the organization. The leadership strives to recruit members who reflect the cultures and ethnic backgrounds of clients, and to provide a mix of competencies that address organizational needs. Specific standards regarding governance and mission are as follows;

- The agency has a clearly stated mission and publicly stated values and goals.
- The agency is operated/overseen by a legally or officially established governing body, with a set of governing documents or by-laws. This governing body has full authority and responsibility for the operation of the organization.
- The governing body is self-perpetuating and has a recruitment and periodic replacement process for members to assure continuity and accountability.

- The governing body hires, supervises, and collaborates with a chief executive officer or director. Together the executive and governing bodies provide organizational leadership.
- The governing body has final accountability for all programs. Through a collaborative relationship with the executive and the management team, the governing body is responsible for developing the program goals and mission and ensuring compliance with legal and regulatory requirements.

10.3 Well Integrated and Organized Management and Operating Structure

The Lead Center will be able to function in an efficient and effective manner, assuring consistency and quality in performance and responsiveness to the needs of families. The applicant shall provide clear identification of who is accountable for the performance of Lead Center services. This includes administration, clinical program quality, management of service delivery and overall financial management.

10.3.1 Administration

Specific standards regarding administration are as follows:

- The executive, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing bodies' strategic goals.
- A current organizational chart which clearly defines lines of authority within the organization must be maintained and provided as part of the certification application
- Staff qualification requirements are clearly identified (e.g. job descriptions) and are approved by the governing body.
- The agency consistently seeks and obtains significant client/family and community input in development, oversight and evaluation of programs.
- The management of the organization is involved in the planning process for performance improvement and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement plan.
- There is a written corporate compliance plan in place that is adopted by the governing body and is reviewed and updated annually.

10.3.2 Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to clients. Fiscal management is conducted in a way that supports the organization's mission, values, and goals and objectives in accordance with responsible business practices and regulatory requirements. Financial management requires a set of sophisticated financial planning and management capabilities if the organization is to remain viable. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must have access to and regularly use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes.

Specific standards regarding financial systems are as follows:

- Financial Management is provided by a Manager with demonstrated experience and expertise in managing the finances of a human services organization with third party reimbursement. In larger organizations (e.g. with revenues in excess of \$1 million) this might be an MBA with demonstrated finance experience or a CPA; in smaller organizations a comptroller with a degree in accounting might be sufficient).
- The Organization's financial practices are consistent with the most up to date accounting methods and comply with all regulatory requirements.
- The Organization's financial planning process includes annual budgeting, revenue projections, regular utilization and revenue/expense reports, billing audits, annual financial audits by an independent CPA, and planning to ensure financial solvency.
- The Organization has written policies and procedures that guide the financial management activities (including written policies for and procedures for expenditures, billing, cash control; general ledger, billing system; registration/intake system; payroll system; accounts payable; charge and encounter reporting system and accounting administration).
- Organization has evidence of internal fiscal control activities, including, but not limited to: cash-flow analysis, review of billing and coding activities.

- The system must track utilization of service units separately for each individual client and aggregate this information by payor, performing provider and diagnosis/problem
- The Organization has a billing office/function that bills for services rendered and collects fees for service and reimbursement.
- The Organization assesses potential and actual risks, identifies exposures, and responds to these with preventive or corrective measures.
- The Organization carries appropriate general liability insurance, and ensures that appropriate professional liability policies are maintained for program personnel.
- Where the Organization contracts with outside entities and/or providers, policies and procedures mandate contract language to detail the entity's or provider's accountability to the Governing Body and its by-laws.
- The Organization has systems that facilitate timely and accurate billing of fee-for-service, capitated and case-rated insurance plans, clients and other funding sources. Once bills are forwarded to payors, the system properly manages payments, follow-up billing, collection efforts and write-offs.
- The Organization has a written credit and collections manual with policies and procedures that describes the rules governing client and third-party billing. Specifically, the organization has in place and adheres to policies and procedures ensuring compliance with Medicaid regulations pertaining to coordination of benefits and third party liability. Medicaid by statute and regulation is secondary payer to all other insurance coverages.
- Clinical, billing and reception/intake staff receives ongoing training and updates regarding billing and collection rules and regulations changes.

10.4 Human Resources, Staffing

Human Resource activities within the CLC organization are conducted to ensure that proper staffing for optimum service delivery to clients occurs through hiring, training, and oversight of staff activities. The activities are organized to serve the governing principles of the organization and compliance with these certification standards. The organization provides clear information to employees about job requirements and performance expectations, and supports continuing education, both internal and external, that is relevant to the job requirements of the individual. In addition, all staff receive training about major organizational initiatives and about key issues that may affect the organization overall. *(See Appendix S, Human Resources Guidance.)*

A successful CLC applicant will have written policies and procedures in place to hire and train individuals who are participating in the Family Independence Program (FIP.) This

program must have stated goals and the progress toward those goals must be reported to DHS upon request. (See Section 6.2)

10.5 Quality Performance Improvement

The organization is required to have policies and procedures and demonstrable activities for quality review and improvement (e.g. formal Quality Assurance or Performance Improvement plan). The organization ensures that information is collected and used to improve the overall quality of service and performance of the program. The Quality Assurance/Performance Improvement (QA/PI) plan that the organization develops strives to: improve the systems related to the delivery of service to the clients; include the preferences of clients in the provision of services; and measure the process and outcomes of the program services. The QA/PI plan is an ongoing process of planning, monitoring, evaluating, and improving the system in order to improve the outcomes of service provided to clients.

Standards regarding Quality Assurance/Performance Improvement are as follows:

- The organization has a Quality Assurance/Performance Improvement plan that includes a written performance improvement plan with annual review of goals and objectives, data analysis, outcomes management, records review and operational/systems improvement. Written records are maintained for QA/PI program activities.
- The QA/PI plan contains specific timetables for activities and measurable goals and objectives, which consider client concerns and input.
- Effective data analysis is conducted that includes an assessment of client or organizational needs, identification of service gaps, and integration of that data into organizational decision-making processes

10.6 Information Management, Record Keeping

The organization must use data to affect the performance, stability, and quality of the services it provides to clients, in its governance, and other systems and processes. (*See Appendix T, Information Management Guidance*)

Standards regarding information management and record keeping are as follows:

- The Organization maintains a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.

- The Organization shall ensure that its information management systems are protected from unauthorized outside access and shall meet all applicable HIPAA regulatory requirements.
- The information management plan specifies standard forms and types of data collected for client intake, admission, assessment, referral, services, and discharge.
- The information management plan has an incident reporting and client grievance-reporting component.
- The client record will be the basis for billing. All service billings must be substantiated in the client record. (*See Appendix U, Certified Lead Centers Documentation Guidelines*)

10.7 Health and Safety, Risk Management

The organization supports an environment that promotes optimal safety and reduces unnecessary risk for clients, family members and staff. The home-based nature of Lead Center services calls for specific policies and procedures to assure that services are provided in a safe and effective manner for the child, family members and staff.

APPENDIX A

APPLICATION GUIDE FOR CERTIFIED LEAD CENTERS

APPENDIX A APPLICATION GUIDE FOR CERTIFIED LEAD CENTERS

GENERAL INFORMATION

1. Overview

This application guide is provided as a part of the Certification Standards for Certified Lead Center providers, and provides information and instructions regarding the submission process and the review of applications. It is intended to direct applicants in the organization and presentation of application materials.

2. Application Submission and Review

Letters of Interest and Applications for Certification are to be submitted to:

Sharon M. Kernan, MPH
Assistant Administrator
Family & Children Services

Center for Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, Rhode Island 02920
Phone: (401) 462-3392

Applicants for certification must submit an original and five (5) copies of all materials.

3. Compliance Review

Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review. Completed applications may be re-submitted at a later date.

4. Application Scoring

The Certification Standards for Lead Centers outline the terms and conditions that will govern operation and oversight of certified providers. Applications will be scored based on the degree to which an applicant describes a program that complies with the requirements set forth in the Certification Standards.

In some areas the requirement is straightforward and the applicant needs to briefly confirm that it understands the requirement and will comply with it. In other areas, thorough descriptions are required of the ways in which the applicant will comply with the standards. Applications will be structured accordingly. As directed, applicants will:

- a) Briefly (in a paragraph or two) confirm understanding and compliance. In these cases responses will be scored as in compliance or not in compliance. No specific weight or scoring will be attached to those responses. Compliance is required for initial and continuing certification; or
- b) Provide sufficient description of the program so that the applications can be scored by the Review Committee for compliance with the standards. Scoring of responses in these areas will be weighted and contribute to the total score.

The following table provides a scoring process overview:

TABLE I

Application Component	Response Required	Page Maximums	Scoring Weight
Section 6: Requirements for Organization of Service Delivery			
6.0 Acceptance of all Referrals, Provide Authorized Services	Confirm understanding and compliance	Less than one page	Not applicable
6.2 Family Centeredness, Client Rights, Ethical Standards of Practice	Description of program approach	2 pages	10%
6.3 Strength of Program Approach			
6.3.1 Process of Care	Description of program approach	7 pages	20%
6.3.2 Management of Services	Description of program approach	7 pages	20%
6.4 Timeliness of Services	Description of program approach	1 page	5%
6.5 Service Monitoring and Reporting	Description of program approach	1 page	10%
6.6 Record Keeping Requirements	Description of program approach	2 pages	5%
6.7 Emergency Procedures	Description of program approach	2 pages	5%
Total for Section 6			75%
7.0 Requirements for Qualified Entity			
7.1 Incorporation and Accountable Entity	Description of program approach	2 pages	5%

Application Component	Response Required	Page Maximums	Scoring Weight
7.2 Governance and Mission	Confirm understanding and compliance	Less than one page	Not applicable
7.3 Well integrated and organized Management and Operating Structure			
7.3.1 Administration	Confirm understanding and compliance	Less than one page	Not applicable
7.3.2 Financial Systems	Confirm understanding and compliance	Less than one page	Not applicable
7.4 Human Resources, Staffing	Confirm understanding and compliance	Less than one page	Not applicable
7.5 Quality Performance Improvement	Description of program approach	3 pages	10%
7.6 Information Management, Record Keeping	Confirm understanding and compliance	Less than one page	Not applicable
7.7 Health and Safety, Risk Management	Description of program approach	2 pages	10%
Total for Section 7			25%

Each individual standard is weighted for its contribution to overall scoring within the respective application component.

Level of proposal compliance with each standard will be scored individually. Based on review of applications, each standard will be scored as follows:

- Score 1 *Inadequate Compliance* The organization fails to meet the expectations of the standard.
- Score 2 *Limited Compliance* The organization meets few expectations of the standard.
- Score 3 *Partial Compliance* The organization meets some expectations of the standard.

Score 4 <i>Significant Compliance</i>	The organization meets most of the expectations of the standard and its approach demonstrates sufficient understanding of, and commitment to, program expectations.
Score 5 <i>Substantial Compliance</i>	The organization consistently meets or exceeds all major expectations of the standard and demonstrates particular strength in its approach.

Certification applications will be independently reviewed by assigned members of the review team. The review team may choose to conduct a site visit and readiness review in order to complete its work. The final score for each standard will be the average of the scores assigned by the review team members. A threshold total score for all areas will be established as the basis for recommendation for provisional certification. Certification will not be recommended for an applicant scoring below three on any individual standard. For certain standards a higher minimal threshold may be established.

A key element in review is the applicant's readiness to begin services. Applicants are expected to demonstrate their ability to begin service delivery not later than thirty (30) days from formal notification of certification.

APPLICATION GUIDE FOR CERTIFICATION AS A LEAD CENTER

Instructions: Certification as a Lead Center provider is achieved through State approval of this written application and on-site review (optional based on State discretion). This application guide identifies the information required to conduct the certification review. All sections should be completed fully so as to sufficiently describe the applicant's approach to meeting the certification standards. Additional materials may be attached as appropriate.

1. Letter of Transmittal

Each application must include a letter of transmittal signed by an owner, officer or authorized agent of the applicant. The letter shall identify that in submitting the application it is understood that the applicant agrees to comply with the program requirements and certification standards as issued and amended from time to time. DHS reserves the right to amend these requirements with reasonable notice to participating providers. The applicant further understands that as a provider within the Medicaid program it is obligated to comply with all state and federal rules and regulations that apply to Medicaid providers more generally.

2. Executive Summary

The Executive Summary is intended to highlight the contents of the application and provide the review team with a broad understanding of the applicant's structure and approach.

3. Cover Sheet

Name of Corporation Submitting Application:

Name and Title of Person Authorized to Conduct Business on Behalf of Corporation:

Name: _____

Title : _____

Contact Person for Questions on Application:

Address (street):

City or Town: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Federal employee identification number: _____

Medicaid Provider Number (if applicable): _____

Date of Application Submission: _____

4. Background on Applicant

To orient the reviewer and facilitate understanding of the materials that follow, please provide a brief introduction to the application. This might, for example, describe some of the background considerations leading to submission of the application and/or the structure of the organizational partnerships and affiliations represented. Formal affiliations should be identified.

5. Body of Application

The main body of the application should be organized as delineated below. This sequencing corresponds with that contained in Sections 6, *Certification Standards* and Section 7, *Qualified Entity*. Applicants should reference Sections 6 and 7 in particular and the Certification Standards more generally for further guidance in addressing individual items. Any changes, amendments or clarifications to the Certification Standards will be distributed to all entities, which have submitted a formal Letter of Interest as outlined above.

6. Certification Standards

Section 6.0: Requirements for Organization of Service Delivery

An applicant for certification must demonstrate that it possesses a sound combination of case management, skills and experience, and the capability to reliably provide needed services

Section 6 delineates the certification requirements, which must be addressed in the certification application. Applicants are to describe the way in which their agency will comply with the requirements.

- 6.1 Agreement to Accept all Referrals, Provide Authorized Services
- 6.2 Family Centeredness, Client Rights, Ethical Standards of Practice
- 6.3 Strength of Program Approach: Process of Case Management Services
 - 6.3.1 Process of Care
 - 6.3.1.1 Treatment Approach and Guidelines
 - 6.3.1.2 Screening and Intake
 - 6.3.1.3 Assessment and Treatment Planning
 - 6.3.1.4 Treatment Plan Implementation
 - 6.3.1.5 Treatment Plan Modification
 - 6.3.2 Management of Services
 - 6.3.2.1 Staff Roles and Scope of Practice
 - 6.3.2.2 Supervision
 - 6.3.2.3 Staffing and Staff Qualifications
- 6.4 Timeliness of Service, Other Access Standards
 - 6.4.1 Hours of Service
- 6.5 Service Monitoring and Reporting
- 6.6 Record Keeping Requirements
- 6.7 Emergency Procedures

Section 7.0: Qualified Entity

- 7.1 Incorporation and Accountable Entity
 - 7.1.1 Partnership or Collaboration
- 7.2 Governance and Mission
- 7.3 Well Integrated and Organized Management and Operating Structure
 - 7.3.1 Administration
 - 7.3.2 Financial Systems
- 7.4 Human Resources, Staffing
- 7.5 Quality Assurance/Performance Improvement
- 7.6 Information Management, Record Keeping
- 7.7 Health and Safety, Risk Management

7. Readiness

It is expected that certification applications submitted to the State will describe a structure and approach to service delivery, which is substantially complete at the time of submission. Applicants will be expected to be able to provide services in accordance with Lead Center

requirements not later than thirty (30) days following notification of the approval of their application. Part of the certification review involves assessment of readiness. Information must be provided that will enable the State to make informed assessments regarding readiness. The State recognizes that in some cases certain aspects of the application may describe intentions of the Certified Lead Center certification applicant rather than capacity actually in place on the date of submission of the application. The applicant should clearly identify the points at which the application describes currently existing versus planned activities and capacity. This section of the application should provide specific appropriate detail as to any outstanding tasks and associated time lines for completion. Additionally, it is anticipated that applications may represent the combined efforts of more than one entity. Application submissions should include copies of all executed contracts and/or affiliation and partnership agreements which detail respective responsibilities, authorities and related financial arrangements. This shall include pertinent incorporation documents or filings.

1. Overview of Application and Review Process
 - 1.1. Applications Submission and Review
 - 1.2. Compliance Review
 - 1.3. Application Scoring

2. Application Guide
 - 2.1. Letter of Transmittal
 - 2.2. Executive Summary
 - 2.3. Organization of Contents of Application
 - 2.4. Readiness

8. Compliance Requirements

In submitting this application to serve as Certified Lead Center, the applicant agrees to comply with the program requirements as outlined. DHS further reserves the right to amend these requirements, from time to time, with reasonable notice to participating providers.

The applicant further understands that as a provider within the Medicaid program it is obligated to comply with all state and federal rules and regulations that apply to Medicaid providers more generally and Department of Health Rules and Regulations for Lead Poisoning Prevention.

Application for Certification as a Provider of Lead Center Services

Name of
Organization: _____

Name of Program (if different from above): _____

Contact Person: _____

Address (street): _____

City or Town: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Federal employee identification number: _____

Medicaid Provider Number (if applicable): _____

Instructions: Certification as a provider of case coordination is achieved through DHS approval of this written application and on site review (optional). This application form identifies the information required to conduct the certification review. To facilitate review please complete as completely as possible. Additional materials may be attached as necessary. This application form is available on disk.

APPENDIX B

ACCEPTANCE OF CLC SERVICES AND LEAD CENTER
CHOICE FORM

APPENDIX B

XYZ Lead Center

Address

Phone:

Fax:

ACCEPTANCE OF CERTIFIED LEAD CENTER SERVICES AND LEAD CENTER CHOICE FORM

Child's Name: _____ DOB: _____

SSN/MID: _____

Parent or Guardian's Name: _____

Address: _____

Phone: _____

XYZ Lead Center has explained services available for a lead poisoned child and I understand that my child, who is lead poisoned, is eligible for these services through the Certified Lead Center program established by the Rhode Island Department of Human Services.

_____ I ACCEPT services from the XYZ Lead Center for my child.

I hereby authorize the XYZ Lead Center to maintain a confidential record for my child.

I understand that this record is protected under the Federal Confidentiality Regulations (42 FCR Part 2), and cannot be disclosed without my written consent except as otherwise specifically provided by law.

I have received information on other Certified Lead Centers and I am aware that I can choose to receive services from any RI Department of Human Services Certified Lead Center:

_____ I DO NOT ACCEPT services from XYZ Lead Center for my child at this time.

Certified Lead Centers in Rhode Island

Blackstone Valley Community Action	32 Goff Avenue, Pawtucket, RI 02860	723-4520
East Bay Community Action	19 Broadway, Newport, RI 02840	848-6697
St. Joseph's Hospital Lead Center	21 Peace Street, Providence, RI 02907	456-4310
West Bay Community Action	205 Buttonwoods Avenue, Warwick, RI 02886	732-4660

Signature of Parent or Guardian

Date

APPENDIX C

**CERTIFIED LEAD CENTERS
SERVICE DESCRIPTION AND CRITERIA FOR LEAD
POISONED CHILDREN WITH BLLs ≥ 15 $\mu\text{g}/\text{dL}$**

APPENDIX C

CERTIFIED LEAD CENTERS SERVICE DESCRIPTION AND CRITERIA FOR LEAD POISONED CHILDREN WITH BLLS ≥ 15 $\mu\text{g}/\text{dL}$

Assessment of Home, Physical and Family Environment to Determine Suitability to Meet Patient's Medical Needs

Billing Code T1028 (This is the INITIAL home visit and comprehensive assessment, including visual assessment)

The initial Home, Physical and Family Environment Assessment is required to engage the family of a lead poisoned child and upon which to build the Family Care Plan and case management services. It is expected that the CLC will contact most families within 72 hours of the referral, (and immediately or within 24 hours for children with BLLs of ≥ 40 $\mu\text{g}/\text{dL}$ or a hospitalized child) The CLC should take following actions in this initial assessment:

1. Obtain a signed agreement by the family for CLC case management services.
2. Verify health insurance coverage and facilitate the RItE Care application process for non-Medicaid children/families.
3. Conduct a medical status determination in cooperation with the child's Primary Care Physician (PCP), which includes consensus on the lead poisoning level, the child's immunization status, and any previously identified, or current medical issues or problems.
4. Create an inventory of all of the providers/locations of care and social services with which the child is actively involved.
5. Identify adult and sibling family members, the family's needs, and the health, lead screening status for all other children 0-72 months and pregnant women in the household. Assess if the child and family can safely stay in home; if they cannot, assist family with finding transitional housing (KIDSNET may be accessed for BLLs for other children).
6. Conduct a comprehensive environmental inventory with visual assessments of all of the locations (in-home, outdoors and non-home) where the child goes, summarizing the potential lead sources in the child's 24 hour/7 day environment (achieved through in-home or other on-site visits).

7. Provide one-on-one education with the child's family (or caregivers) on lead poisoning, emphasizing interim lead safe measures and lead hazard reduction to prevent re-exposure for in-home, outdoor and non-home settings; nutritional approaches to reduce blood lead levels (BLL) and prevent re-poisoning, and the importance of periodic BLL rechecks.
8. Provide one-on-one cleaning demonstration, identification of duct tape application uses with demonstration of duct tape; demonstrate HEPA vac use; lend HEPA vac, as necessary.
9. Institute immediate temporary environmental lead control measures and intensive environmental cleaning, as required, with at least one follow-up home visit to confirm environmental compliance; assessments and interventions should be documented in the case record.
10. Initially assess the family's ability to institute and maintain intensive cleaning. Instruct and provide guidance and demonstration as needed. Initiate intensive cleaning when family is unable to perform cleaning.
11. Begin to develop an individualized Family Care Plan (FCP) in coordination with the child's family, focusing on the immediate environmental lead hazard reduction needs with family specific child-safe measures consistent with the Visual Assessment (or the DOH Comprehensive Environmental Lead Inspection Report, when available).

Comprehensive Community Support Services (intensive case management)

Billing Code H2016-TG (The TG modifier is used for intensive case management and denotes a complex/high tech level of care.)

Comprehensive Community Support Services follow the initial in-home assessment and creation of the Family Care Plan. It is anticipated that the time intensity of this level of service should be approximately 5 to 8 hours per case/per month with the maximum duration of intensive services up to six (6) months. The following responsibilities are integral to successful provision of intensive Comprehensive Community Support Services. CLCs must:

1. Reinforce previously provided one-on-one education with the child's family (or caregivers) on lead poisoning, as necessary, emphasizing interim lead safe measures and lead hazard reduction to prevent re-exposure for in-home, outdoor and non-home settings; nutritional approaches to reduce blood lead levels (BLL) and prevent re-poisoning, and the importance of periodic BLL rechecks.

2. Reinforce previously provided one-on-one cleaning demonstration, as necessary; identification of duct tape application uses with demonstration of duct tape; demonstrate HEPA vac use; lend HEPA vac, as necessary.
3. Reinforce temporary environmental lead control measures and intensive environmental cleaning, as required, with at least one follow-up home visit to confirm environmental compliance; assessments and interventions should be documented in the case record.
4. Fully develop an individualized Family Care Plan (FCP) in coordination with the child's family, FIP caseworker, PCP and/or Lead Clinic and health plan, based upon the family and environmental assessments. The FCP includes the planning, monitoring, and tracking for all referrals to needed services as identified in the family assessment and identifies all services to be coordinated and provided by the CLC, focusing not just on the child but on the family as a whole. The FCP should include a housing plan and lead hazard reduction action plan, developed with family specific child-safe measures consistent with the Visual Assessment and Comprehensive Environmental Lead Inspection Report, when available.
5. Regularly and systematically reassess the family's ability to institute and maintain intensive cleaning. Instruct and provide guidance and demonstration as needed. Initiate intensive cleaning when family is unable to perform cleaning.
6. Regularly and systematically review the Family Care Plan with the family and relevant partners to ensure its relevance and to ensure that areas of need are being addressed, responsible parties are following through, and that barriers to progress are overcome.
7. Facilitate or explain Comprehensive Environmental Lead Inspection per state regulations (DOH inspection if eligible) or CLC certification standards for those ineligible for DOH inspection to families.

Comprehensive Community Support Services (maintenance case management)

Billing Code – H2016

Maintenance level Community Support Services are a continuation of intensive case management services at a lesser intensity. This can be expected to occur when the family understands and has instituted temporary lead safe measures and the Family Care Plan is in place and progressing. Services should include all core requirements, as well as any other required services/referrals as detailed in the CLC Certification Standards. Maintenance activities are expected to range from 2 to 4 hours per month and are limited to a total of four (4) months:

1. Reinforce maintenance of regular and effective environmental cleaning and temporary measures, as required, with appropriate follow-up to ensure continued environmental compliance.
2. Following initial contact with PCP and provision of initial FCP and CLC policies and procedures, provide progress updates and at least monthly reviews with revisions, as necessary, to the FCP. FCP reviews should be documented in the case file (paper or electronic).
3. Complete Developmental Assessment and provide a copy to PCP (Completed Age-specific Developmental Assessments should also be filed in the case record).
4. Closely monitor on-schedule repeat BLL follow-up as ordered by the PCP or Lead Clinic (and as documented in FCP) with immediate family follow-up if overdue.
5. Follow-up with family to ensure that it is seeking, accessing and receiving referral services; identify barriers and collaborate with family on problem solving strategies in accessing services.
6. Verify health insurance coverage and facilitate the RItE Care application process for non-Medicaid children/families as family socio-economic situation changes. Encourage RItE Care recertification, as necessary.
7. Refer all Medicaid-eligible children to WIC and Food Stamps (if not already enrolled) with appointment scheduling, if necessary, and follow-up to ensure family is accessing WIC services and Food Stamps.
8. Support families enrolled in RItE Care/RItE Share for the first time and assist families in accessing services.
9. Review DOH Environmental Inspection Report findings and recommendations with family and provide reinforcement or additional education, as appropriate.
10. Provide intensive housing advocacy activities, as appropriate.
11. Assist in finding permanent lead safe housing, as needed.
12. Refer for and assist with permanent housing relocation assistance activities, as needed.
13. Refer to other abatement programs, (e.g., RI Housing and Mortgage Finance Corporation, Providence Housing, Community Action Weatherization Programs), as needed.

14. Coordinate Window Replacement and Spot Repair/Removal services, as needed and appropriate.
15. Participate in medical case conferences upon request or when necessary and appropriate.
16. Identify and encourage parents/caregivers to access legal services, peer counseling and parent support groups, as appropriate.
17. Provide instruction on HEPA vac use; lend HEPA vac to family
18. Conduct visual assessment of proposed new housing unit if family decides to move

Assessment of Home, Physical and Family Environment to Determine Suitability to Meet Patient's Medical Needs (Case Closure Follow-up) Billing Code T1028-TS (The TS modifier denotes Follow-up)

This service may be billed for a family that has accepted CLC services, moved through the stages of change, and has demonstrated sufficient understanding through action to effectively reduce their lead poisoned child's exposure to lead, and no longer requires case management. The family should be able to transfer lead education knowledge to other settings and understand the importance of a lead-safe setting for future housing, day care locations as well as any other locations where children in the family might go. The goal of this intervention is to create families who can provide self-care through child-safe environmental compliance to prevent lead re-poisoning and to prevent future lead poisonings of any other children in the household.

The family should be in agreement that closure is appropriate. The CLC must obtain a signed agreement from the family to close the case to CLC case management services and provide a discharge plan with information for aftercare.

This code may be billed once per family per 365 days, following a service sequence consisting of an Assessment of Home, Physical and Family Environment (Initial In-Home) Assessment and Comprehensive Community Support (case management) services. This service may not be billed until window replacement; spot repair/removal and clearance inspections have been completed. It is inappropriate to bill this service for families, who are never served, lost to follow-up, are unresponsive or who refuse further services.

APPENDIX D

LEAD HAZARD REDUCTION CHECKLIST

LEAD HAZARD REDUCTION CHECKLIST

NAME:	
DOB:	Date Referred by DOH:
MID:	PCP

Problem & Status A'Active, D'Deferred, R'Resolved N'No Issue	Measurable Goals	Referrals & Provider(s)	Frequency & Duration	Monitoring Responsibility Family, CLC, PCP, or Other	Date To Be Achieved	Actual Achievement Date
Lead Education						
Environmental Assessment						
Environmental Cleaning						
Lead Hazard Interim Measures fully implemented						
Nutrition Education/Counseling						
Review of Housing Inspection Report With Family						
Eligibility status for Medical Assistance, Rite Care/Rite Share						
Repeat F/U BLLs Frequency and Results						
Follow-up Visits With Lead Clinic or PCP						
WIC Referral						
Family Relationships						
Social Issues						
Landlord Issues						
Legal Issues						
Abatement Issues						
Housing/Relocation						

Problem & Status A'Active, D'Deferred, R'Resolved N'No Issue	Measurable Goals	Referrals & Provider(s)	Frequency & Duration	Monitoring Responsibility Family, CLC, PCP, or Other	Date To Be Achieved	Actual Achievement Date
Issues						
Eligibility for Window Program						
Developmental Assessment						

APPENDIX E

**SAMPLE LETTERS FOR COMMUNICATION WITH
FAMILY AND CHILD'S PCP OR TREATING PHYSICIAN**

<Date>

<Primary Care Provider>

<Address>

<City, State, Zip>

RE: <Child's Name> <DOB>

Dear <Primary Care Provider>,

The < Lead Center> has begun providing non-medical case management services to your patient, < Child's Name> and <Date of Birth>. The family has authorized us to release information to you. Copies of the Lead Center's Initial Family Care Plan Summary and the Home Visual Inspection Report are enclosed to keep you informed about the proposed strategies to eliminate sources of lead and its negative effects for this child. You are welcome to use this Family Care Plan in reinforcing childhood lead poisoning prevention education.

Certified Lead Centers provide or coordinate:

Lead-related Education – In-home lead education and demonstration of wet cleaning and barrier techniques, as well as ways to prevent further poisoning. Nutritional guidance is included in lead-related education as well as the importance of regular follow-up blood testing to monitor the child's blood lead level.

Developmental Assessments – Assessments include mental, motor and behavior development

Non-Medical Case Management – Referral assistance and advocacy in receiving other services (i.e., WIC, Head Start, RI Legal Services)

Housing Information and Inspection Assistance – Information and assistance in working with the property owner or landlord in making the home lead safe

Window Replacement and Lead Hazard Spot Repair/Removal – Services available to RIte Care-enrolled children with blood lead levels of 15 µg/dL and above, through RI Medicaid

We look forward to working with you and are available as a resource on childhood lead poisoning to your office. If you wish to speak with the Lead Center case manager responsible for your patient, please telephone < > at < >.

Sincerely,

< Name >

< Title >

Enclosures: Initial Family Care Plan Summary
Home Visual Inspection Report

<Date>

<Parent(s)'s Name>

<Address>

<City, State Zip>

Re: <Child's Name> <Child's Date of Birth>

Dear < Parent/Guardian >,

As your case manager, I am writing to let you know that I do not have a recent follow-up blood lead test for your child < Child's Name > since <Date>.

Children who have been lead poisoned need to have follow-up blood lead testing. Because your child was lead poisoned, your child needs regular follow-up lead testing to show the amount of lead in the blood. A blood lead test is the only way to find out how well the cleaning and other steps to stop lead poisoning are working for your child.

Call your child's doctor right away to get a follow up blood lead test. If you need help in getting this blood test or need transportation assistance, call me at < Telephone Number >.

Sometimes the results of recent blood lead testing at hospital-based labs may not be immediately available to the RI Department of Health. If your child had follow-up blood lead testing within the last month, let me know the name and phone number of the laboratory so that I can get the results of this testing. Thank you for doing all you can to stop lead poisoning.

Sincerely,

<Name>

<Title>

<Date>

<Primary Care Provider>

<Address>

<City, State, Zip>

RE: <Child's Name> <Child's DOB>

Dear <Primary Care Provider>,

As a Case Manager for the < Lead Center >, I have been providing non-medical case management to your patient, <Child's Name >, who had an elevated blood lead level.

The last record of a blood lead test for < Child's Name > available from the RI Department of Health is <__ > µg/dL performed on <Date>. I have been in touch with <Child's Name > family and have suggested that your office be contacted for follow-up blood lead testing.

If you have record of more recent follow-up blood lead testing results, please forward the date and test results to me.

For questions about this correspondence, please telephone me at < Telephone Number >. Thank you for your ongoing work to monitor the blood lead levels and developmental progress of lead poisoned children in your care.

Sincerely,

<Name>

<Title>

<Date>

<Primary Care Provider>

<Address>

<City, State, Zip>

RE: <Child's Name> <Child's DOB>

Dear <Primary Care Provider or Lead Specialist MD>,

I am writing to inform you that <Child's Name> who was referred to the < Name > Lead Center in <Month, Year> for non-medical case management for lead poisoning:

- Has successfully completed case management
- Did not complete case management
- Received window replacement
- Received lead spot removal/repair
- Could not be located

A copy of the closed case report is enclosed. This child's last blood lead level was <__ > µg/dL performed on <Date>. This child will require ongoing blood lead screening as outlined in the RI Universal Blood Lead Screening until the age of 6 years.

In addition to ongoing blood lead monitoring, children who have been lead poisoned require long-term medical and educational assessments, monitoring and management for early identification and interventions to prevent or reduce the consequences of childhood lead poisoning.

Should you require additional information regarding this child, please contact the < Name> Lead Center at <Telephone Number>.

Sincerely,

<Name>

<Title>

cc: Child's Primary Doctor (If this is sent to Lead Specialist MD)
Parent/Guardian

APPENDIX F

SAMPLE REFERRAL LETTER

<Date>

<Referral Provider>

<Address>

<City, State, Zip>

RE: <Child's Name> <Child's DOB>

Dear <Referral Provider>,

I am referring <Child's Name> for additional services and programs offered through your agency, with authorization and release from this child's parent, to prevent or correct consequences of lead poisoning.

Parent or Guardian: < Parent/Guardian Name >

Home Address: < Address >

Telephone: < Number >

Specific services which have been identified in the Lead Center Family Care Plan for this child and family include:

< Specify services >

Your agency might identify other service opportunities as well.

Please facilitate initial contact to this family so that need assessment, and delivery and receipt of services can begin as soon as possible. < Parent/Guardian> is expecting to be contacted by a representative of <Referral Provider>. Please let me know if I can be of further assistance to you in engaging this family for services.

<Case Manager Name> is (or I am) the case manager working with this family on lead-related issues and will follow-up with you in approximately two weeks for a status update. You may reach me at < Telephone Number> between 8AM – 5PM Monday through Friday and for urgent/emergency matters, contact

< Telephone Number>. I look forward to working with you and your staff in coordinating services to this family and to further eliminate lead poisoning sources and its negative effects for this child.

Thank you.

Sincerely,

<Name>

<Title>

cc: Child's Primary Doctor
Parent/Guardian

APPENDIX G

**NUTRITION REFERRAL CRITERIA FOR CHILDREN WHO
ARE LEAD POISONED**

APPENDIX G

NUTRITION REFERRAL CRITERIA FOR CHILDREN WHO ARE LEAD POISONED

Recommended Screening	Standard for Referral to a Licensed Dietician/Nutritionist	Potential Therapeutic Diet or Diet Modification									
Infants 0-12 Months. Measured at all routine preventive visits Underweight Overweight Stunting Inappropriate Growth	Weight for Length >90 percentile Weight for Length <25 percentile Length for Age <5 percentile	Calories, Pediatric Diet Calories, Protein, Pediatric Diet Calories, Protein, Pediatric Diet									
Children 1-6 Years. Measured annually for children 1-6 years of age Underweight Overweight Stunting Inappropriate Growth	Weight for Length or Height >95 percentile Weight for Length or Height <10 percentile Length for Age <5 percentile Increase or decrease of more than 2 standard deviations (channels on growth chart) in established growth pattern	Calories, Pediatric Diet Calories, Protein, Pediatric Diet Calories, Protein, Pediatric Diet Calories, Protein, Pediatric Diet									
Hemoglobin: Screened at 6-9 months, 24 months, more frequently when indicated	<table border="0" style="width: 100%;"> <tr> <td style="text-align: left;">Age</td> <td style="text-align: left;">Sex</td> <td style="text-align: left;">Hgb Level</td> </tr> <tr> <td>6m-4 years</td> <td>both</td> <td><11.0 g/dL</td> </tr> <tr> <td>5-6 years</td> <td>both</td> <td><11.5 g/dL</td> </tr> </table>	Age	Sex	Hgb Level	6m-4 years	both	<11.0 g/dL	5-6 years	both	<11.5 g/dL	<i>Iron, Folic Acid, Vitamin B¹², Pediatric Diet</i>
Age	Sex	Hgb Level									
6m-4 years	both	<11.0 g/dL									
5-6 years	both	<11.5 g/dL									
* Lead Screening	≥ 15 µg/dL	Fat, Calcium, Iron, Pediatric Diet									
*5-37 months, screen annually. If results are ≥ 15 µg/dL screen every 3-4 months. Annual lead screening can be discontinued after 37 months if all the child's previous screening test results were <15 µg/dL											

APPENDIX H

VISUAL ENVIRONMENTAL LEAD ASSESSMENT

APPENDIX H

Child's Name:	_____
Address:	_____ _____
ID#:	_____
DOB:	_____
Approximate age of structure:	_____
Date of Visit:	_____

VISUAL ENVIRONMENTAL LEAD ASSESSMENT

ASSESSMENT Interior (Including Common Areas)	Intact	Cleaned & Covered	Dust	Peeling & Chipping
Window Wells				
Window Sills				
Ceiling				
Door Frame(s)				
Door(s)				
Floor				
Baseboard				
Radiators				
Hallway				
Rear				
Front				
Stairs				
Cabinets/Closets				
Furniture				

Exterior	Intact	Dust	Peeling & Chipping
House			
Porch			
Railing			
Yard			
Grass			
Bare Dirt			
Concrete			
Windows			
All Need Replacement		Some Need Replacement	None Need Replacement

Comments/Follow-up:

Signature

Date

APPENDIX I

**EXAMPLE OF WORK SPECIFICATION REVIEW FOR
WINDOW REPLACEMENT AND/OR SPOT
REPAIR/REMOVAL**

APPENDIX I

**EXAMPLE OF WORK SPECIFICATION REVIEW FOR WINDOW
REPLACEMENT AND/OR SPOT REPAIR/REMOVAL**

Property Address: _____
Year Built _____

City: _____ State: _____ Zip _____ Floor/Apart. # _____

Attach a sketch of housing unit showing all rooms, hallways, common area, number all rooms.

Room #1 _____ name of room) # of windows: _____

Replacement needed: Yes ___ No ___ If yes, # of replacements: _____ Sizes: _____

Spot repair/removal needed: Yes ___ No ___ Describe area: _____

Interior doors needing replacement: Yes ___ No: ___ Number and location: _____

Room #2 _____ name of room) # of windows: _____

Replacement needed: Yes ___ No ___ If yes, # of replacements: _____ Sizes: _____

Spot repair/removal needed: Yes ___ No ___ Describe area: _____

Interior doors needing replacement: Yes ___ No: ___ Number and location: _____

Room #3 _____ name of room) # of windows: _____

Replacement needed: Yes ___ No ___ If yes, # of replacements: _____ Sizes: _____

Spot repair/removal needed: Yes ___ No ___ Describe area: _____

Interior doors needing replacement: Yes ___ No: ___ Number and location: _____

**APPENDIX J
WINDOW REPLACEMENT AND SPOT
REPAIR/REMOVAL PRIOR AUTHORIZATION FORM
AND WORKSHEET**

RHODE ISLAND MEDICAL ASSISTANCE PRIOR AUTHORIZATION REQUEST FORM

RECIP MID (SSN) _____ LAST NAME _____ FIRST NAME _____ MI _____ BIRTH DTE _____

REFERRING MEDICAID PROVIDER NUMBER _____ REFERRING MEDICAID PROVIDER NAME _____

REFERRING NON-MEDICAID PROVIDER NUMBER _____ REFERRING NON-MEDICAID PROVIDER NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____ PHONE _____

DHS ONLY	LINE ITEM	PERFORMING PROV NUM	START DATE	END DATE	NDC/PROC/REV/MOD or NDC/PROC/REV/MOD RANGE	MOD	TTH MOD	TTH SRF	DIAG CODE or DIAG CODE RANGE	UNITS/OCCUR	DOLLAR AMOUNT	POS	SVC CAT

STATEMENT OF MEDICAL NECESSITY _____
 (reason service is required, diagnosis/prognosis and treatment prescribed) _____

REFERRING PROVIDER SIGNATURE AND TITLE _____ REQUEST DATE _____

OFFICIAL USE DHS AUTHORIZED _____ DATE _____
 DO NOT WRITE DHS DENIED _____ DATE _____
 BELOW LINE NOTES _____

Child's Name _____
 SSN _____
 Address: _____ Apt/Unit _____
 City: _____ ZIP: _____

LEAD CENTER REIMBURSEMENT WORKSHEET
(Submit to DHS with Prior Authorization Request)

CODE	SERVICE DESCRIPTION	RATE	NUMBER	TOTAL AMOUNT
X1273	Window Replacement	\$214.00 (per window)		\$ _____
X1274	Spot Repair/Removal	\$150.00 – Work Specifications (specifies window replacement and spot repair /removal to be done, per room).		
		\$175.00 – Spot repair/removal per room (hallway on each floor considered a room).		
		\$125.00 – Interior door replacement, per door. Includes all hardware, hinges, installation and lead-safe removal of old door.		
		\$ 62.00 – Removal and lead safe disposal of old windows, per window.		
		\$225.00 – Exit clearance and certificate of acceptable dust clearance.		
<p>Note: Prior Authorization required for all above services.</p> <p>Code X1273 - Window replacement/refurbishment, is the only service subject to lien. Use the <u>actual number of windows for window units and to calculate total window replacement reimbursement.</u></p> <p>Code X1274 is used for an array of services, but must be authorized/billed as a <u>single (one) unit per date of service.</u></p>			<p align="center">GRAND TOTAL X1274 (Bill as 1 Unit)</p>	<p align="center">\$ _____</p>

APPENDIX K

TEMPLATE LETTER AND LIEN AGREEMENT

DATE: _____

PROPERTY OWNER: _____

ADDRESS: _____

CHILD'S NAME: _____

RE: RHODE ISLAND DEPARTMENT OF HUMAN SERVICES/MEDICAID
WINDOW REPLACEMENT PROGRAM; ACKNOWLEDGEMENT
OF LIEN ON PROPERTY

Dear _____:

As you know, you have received notice from a Rhode Island Certified Lead Inspector that your property contains lead paint dust, and that the child, _____, has documented elevated levels of lead in his/her bloodstream.

As part of its services, the Lead Center has made arrangements, through the Rhode Island Department of Human Services Medicaid program, to have new windows installed in the property and spot removal completed where indicated, at no expense to you at this time. In exchange, you have agreed to execute a promissory note in favor of the State of Rhode Island, which will require reimbursement by you to the state only when title to the property is transferred in the future or upon the death of the record owner. A copy of the promissory note will be placed on file in the land evidence records of the city/town in which the property is located, and you will receive a copy for your records.

The Department of Human Services has asked us to provide you with this letter in order for you to sign it to confirm that you understand that reimbursement to the state will be required when title to the property is transferred to anyone else.

Please sign the attached on the line(s) indicated. **EACH OWNER MUST SIGN THIS LETTER IN THE PRESENCE OF A NOTARY PUBLIC.** A copy of this letter is enclosed for your records.

Sincerely,

<Name-CLC Case Mngr or Director>
<Title>
<CLC>

**Agreement for Lien to be
Placed on Property
Receiving Window Replacement**

Property Owner of Record: _____

Address: _____

Phone: _____

Address of Property Receiving Window Replacement

_____ Indicate if 1st Floor, 2nd Floor etc.

Number of Windows to be Replaced _____ @ \$214.00 each

Amount of Lien \$ _____

I, _____ certify that I am the record owner of property located at _____, and I acknowledge that I have voluntarily agreed to have _____ windows installed at this property. I therefore give my permission and understand a lien will be placed by the Rhode Island Department of Human Services in the amount of \$ _____. I have agreed to the placement of this lien in consideration of the receipt of the funds.

Signature _____

Witness _____

Notarized by _____
STATE OF RHODE ISLAND
COUNTY OF _____

In _____ in said County on the _____ day of _____ and year of _____, before me personally appeared _____, each and all known to be the party(ies) executing the foregoing instrument, and he (she) acknowledged same to be his/her/their free act and deed.

NOTARY PUBLIC
My Commission expires

APPENDIX L

**REQUIREMENTS FOR LEAD CENTER COMPLAINTS
AND GRIEVANCES AND APPEALS PROGRAM**

APPENDIX L

REQUIREMENTS FOR LEAD CENTER INFORMAL COMPLAINTS AND GRIEVANCES AND APPEALS PROGRAM

General

The Lead Center shall have written policies and procedures for resolving member complaints and for processing grievances/appeals requested by the client. Such procedures shall not be applicable to any disputes that may arise between the CLC and any provider regarding the terms, conditions, or termination or any other matter arising under a contract or regarding any payment or other issues relating to providers. CLC agrees to participate in a Department of Human Services Fair Hearing upon request.

Grievance and Appeals Data

The Certified Lead Center agrees to maintain and submit an annual informal complaint grievance and appeals log/report, which conforms to the State's specifications (see examples in this appendix). Reports are due no later than thirty (30) days after the end of each reporting year.

Complaints Resolution

It is the State's preference that CLC's resolve complaints through internal mechanisms whenever possible. The CLC, therefore, agrees to have written policies and procedures for handling complaints registered by its clients. CLC agrees to record and maintain a log of all complaints received, the date of their filing, their current status and to provide reports as requested.

APPENDIX M

LEAD CENTER INFORMAL COMPLAINT SUMMARY

APPENDIX M

LEAD CENTER INFORMAL COMPLAINT SUMMARY

CLC: _____ YEAR ENDING: _____

NATURE OF INFORMAL COMPLAINT	NUMBER OF INFORMAL COMPLAINTS	NUMBER OF COMPLAINTS RESOLVED
1. ADVERSE DECISIONS		
2. TERMINATION OF SERVICES		
3. OTHER		
4. TOTAL		

APPENDIX N

LEAD CENTER GRIEVANCE AND APPEALS LOG

APPENDIX N

LEAD CENTER GRIEVANCE AND APPEALS LOG

CLC: _____

YEAR ENDING: _____

DATE	MEMBER NAME	SOCIAL SECURITY NUMBER	REASON(S) FOR GRIEVANCE/APPEAL	RESOLUTION	DATE RESOLVED	DATE MEMBER NOTIFIED

APPENDIX O

**LEAD CENTER GUIDE TO
COMPLAINTS, GRIEVANCES AND APPEALS**

**COMPREHENSIVE LEAD CENTER FAMILY GUIDE
TO
COMPLAINTS, GRIEVANCES AND APPEALS**

A family may have concerns, complaints or grievances about how it has been treated or if necessary services are delayed, not offered or not provided. Examples of these include unprofessional treatment by Lead Center staff, or a Lead Center decision to not replace or refurbish windows or to end services.

1. A family that has accepted services from the Lead Center is able to receive prompt attention for concerns and disputes through the following steps:

- i. **Informal Complaints** - Contact the case manager or executive director of the Comprehensive Lead Center (CLC). If the family is not satisfied with how an informal complaint has been handled, the family should request a formal grievance with the Lead Center or a Fair Hearing with the Department of Human Services (DHS).
- ii. **Formal Grievances** - If a family is dissatisfied with the outcome of an informal complaint, a formal grievance can be filed with the Lead Center. The Lead Center must answer all formal grievances within thirty (30) days.
- iii. **DHS Fair Hearing and Appeal** - As with any other Department of Human Services (DHS) program, families may request a DHS Fair Hearing for lack of access to or denial of services. Hearing forms (See attached DHS 121-A Form) are available at all DHS Field Offices, or from the RIte Care Info Line or the Spanish Info Line at 462-5300.

If a claim is denied through a Fair Hearing, families have thirty (30) days to file an appeal in Superior Court.

APPENDIX P

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
REQUEST FOR A HEARING FORM (DHS-121)**

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
REQUEST FOR A HEARING**

**DHS-121
REV. 01/90**

SECTION I - IDENTIFYING INFORMATION

NAME

Recipient _____ Category Case Number/Social Security Number _____

ADDRESS _____

Number and Street _____

City/Town _____ ZIP _____

SECTION II - STATEMENT OF COMPLAINT (To be completed by applicant or recipient).

I wish to continue to receive the amount of assistance and/or food stamps I now receive until the hearing decision

I do not wish to continue to receive the amount of assistance and/or food stamps I now receive until the hearing decision

If the hearing decision is not in my favor, I understand that I must repay any assistance and/or food stamps for which I am determined ineligible.

Signature: _____ (Recipient) _____ Date

SECTION III - STATEMENT OF AGENCY POLICY (to be completed by the agency representative)

Date received by Regional or District Office _____

Indicate Specific Manual Reference:

DHS Manual Section _____
 Food Stamp Manual Section _____

Explain agency decision in relation to complaint and policy: _____

Signature of Agency Representative _____

Signature of Supervisor _____

District Office _____

AGENCY USE ONLY

Date received in the hearing office _____ Date of hearing _____

INSTRUCTION FOR COMPLETING DHS-121

This form is used by both the client and the agency representative to:

1. Identify in writing by the client the cause of his/her complaint or grievance; and
2. Identify by the agency representative the policy on which the decision causing the complaint was based.

This form is given to the client at the time s/he decides to appeal an agency decision.

For Food Stamps: A client has 90 days from the date of the Notice of Agency Action to request a hearing.

For All Other Programs: A client has 30 days from the date of the Notice to request a hearing.

Sections I and II

These two sections can be filled out by the client alone, or by the client and agency representative, if the client needs help in completing the form. The section is signed by the person making the complaint.

Section III

After Sections I and II are completed, the agency representative completes Section III, citing the agency policy (ies) with reference to the particular manual sections(s) that was the basis for making the decision. This section is signed by the agency representative and supervisor. The area identifying the area and district are completed. The form is routed promptly to the hearing office at Central Office.

NOTE: When the DHS-121 is completed by the client and mailed directly to Central Office, without being routed through the regional or district office, the hearing office makes a copy of the DHS-121. The original is sent to the regional or district office for completion of Section III. The DHS-121 must be returned to the hearing office at Central Office within seven (7) days.

Legal Help

At the scheduled hearing, you may represent yourself, or be represented by someone else such as a lawyer, a relative, a friend, or another person. If you want free legal help, call Rhode Island Legal Services at 274-2652 (outside the Providence calling area, call toll free at 1-800-662-5034).

APPENDIX Q

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
INFORMATION ABOUT HEARINGS FOR APPLICANTS
AND RECIPIENTS OF FINANCIAL ASSISTANCE, FOOD
STAMPS, MEDICAL ASSISTANCE AND SOCIAL
SERVICES**

INFORMATION ABOUT HEARINGS FOR APPLICANTS AND RECIPIENTS OF FINANCIAL ASSISTANCE, FOOD STAMPS, MEDICAL ASSISTANCE AND SOCIAL SERVICES

The Department of Human Services (DHS has a responsibility to provide financial assistance, food stamps, medical assistance, and social services to individuals and families for who eligibility is determined under the provisions of the Social Security Act, the Rhode Island Public Assistance Act, the Food Stamp Act, the Rhode Island Medical Assistance Act and Title XCX Social Services.)

The hearing process is intended to insure and protect your right to assistance and your right to have staff decisions reviewed when you are dissatisfied. You have asked for a hearing because of an agency decision with which you disagree. The following information is sent to help you prepare for your hearing and to inform you about what you may expect and what will be expected of you when it is held.

WHAT IS A HEARING?

A hearing is an opportunity provided by the Department of Human Services to applicants or recipients who are dissatisfied with a decision of the agency, or delay in such a decision for a review before an impartial appeals officer to insure correct application of the law and agency administrative policies and standards.

WHO CONDUCTS A HEARING?

A hearing is conducted by an impartial appeals officer appointed by the Director of the Department of Human Services to review the issue(s) and give a binding decision in the name of the Department of Human Services.

WHO MAY ATTEND A HEARING?

A hearing is attended only by persons who are directly concerned with the issue(s) involved. You may be represented by legal counsel if you choose and another witness or a relative or friend who can speak on your behalf. The Agency is usually represented by the staff member involved in the decision and/or that worker's supervisor. Legal services are available to persons wishing to be represented by legal counsel through Rhode Island Legal Services (247-2652) or (1-800-662-0534).

If an individual chooses to have legal representation, e.g. be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. It is also needed for the representation for purposes of follow-up, review, request for continuances, etc.

WHERE IS THE HEARING HELD?

The hearing may be held at a regional or district office or in an individual's home when circumstances require.

HOW CAN YOU LEARN ABOUT THE DEPARTMENT'S RULES AND REGULATIONS?

Section III of the attached form (DHS-121) shows the policy manual references, which are at issue in your hearing. You may review the Department's regulations at any local welfare office during regular business hours.

You may also review the Department's hearing decision rendered on or after April 1987. They are available only at the DHS Central Administration Building, 600 New London Avenue, Cranston, Rhode Island, between the hours of 9:00 a.m. and 11:00 a.m. and between the hours of 1:00 p.m. and 3:00 p.m. Monday through Friday.

WHAT ARE YOUR RIGHTS RELATIVE TO THE HEARING?

You have a right to examine all documents and records to be used at the hearing at a reasonable time before the date of the hearing, as well as during the hearing.

You may present your case in any way you wish without undue interference, by explaining the situation yourself or by having a friend, relative, or legal counsel speak for you, and you may bring witnesses and submit evidence as discussed above to support your case. You will have an opportunity to question or refute any testimony or evidence and to confront and cross-examine adverse witnesses.

HOW IS A HEARING CONDUCTED?

A hearing differs from a formal court procedure because you are not on trial and the appeals officer is not a judge in the courtroom sense. However, any person who testifies will be sworn in by the appeals officer.

After you have presented your case, the staff member will explain the provisions in law or agency policy under which s/he acted. When both sides have been heard, there will be open discussion under the leadership and guidance of the appeals officer. The entire hearing is recorded on tape.

HOW WILL THE HEARING DECISION BE MADE?

The tape recording of the testimony of the persons who participated in the hearing, together with all papers and documents introduced at the hearing, will be the basis for the decision.

The appeals process is generally completed within 30 days of the receipt of your request, but will never exceed sixty (60) days for food stamps and ninety (90) days for all other programs unless you request a delay, in writing, to prepare your case.

The appeals officer will inform you of her/his findings, in writing, following the hearing. If you are still dissatisfied, you have a right to judicial review of your case. The agency staff member wants to be as helpful as possible in assisting you to prepare for the hearing. If you have any questions about what you may expect, or what may be expected of you, be assured that you may call your eligibility technician or worker.

APPENDIX R
REIMBURSEMENT RATES
EFFECTIVE MAY 1, 2006

**APPENDIX R
REIMBURSEMENT RATES
EFFECTIVE May 1, 2006**

NATIONAL CODE DEFINITION	National Code	Modifier	Max Allowed Amount	Max Units
COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER DIEM (limited to 6 months)	H2016	TG	\$6.35	1
COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER DIEM (limited to 4 months)	H2016		\$2.58	1
ASSESSMENT OF HOME, PHYSICAL AND FAMILY ENVIRONMENT, TO DETERMINE SUITABILITY TO MEET PATIENT'S MEDICAL NEEDS (INITIAL VISIT/HOME ASSESSMENT)	T1028		\$205.92	1
ASSESSMENT OF HOME, PHYSICAL AND FAMILY ENVIRONMENT, TO DETERMINE SUITABILITY TO MEET PATIENT'S MEDICAL NEEDS (CLOSURE/FINAL HOME ASSESSMENT FOLLOW-UP)	T1028	TS	\$257.41	1
WINDOW REPLACEMENT/REFURBISHMENT	X1273		\$214.00	30
PRE AND POST INSPECTIONS AND SPOT REMOVAL	X1274		Variable	1
MODIFIER DESCRIPTION	Modifier			
Complex/High Tech Level of Care	TG			
Follow-up	TS			

APPENDIX S

HUMAN RESOURCES GUIDANCE

APPEXDIX S HUMAN RESOURCES GUIDANCE

Specific recommendations regarding Human Resources and staffing are as follows:

- The organization's personnel practices contribute to the effective performance of staff by hiring sufficient and qualified individuals who are culturally and linguistically competent to perform clearly defined jobs.
- Employee personnel records are kept that contain a checklist tickler system to track appropriate training, credentialing and other activities.
- Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
- Staff is hired that match the requirements set forth in both the appropriate job description and in the policies and procedures.
- Each employee's record contains a job description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. Supervisory job descriptions establish expectations for both contributing to the organization's goal attainment and for communicating the goals and values of the organization. All job descriptions include standards of expected performance.
- The Organization provides a clear supervisory structure that includes plainly delineated spans of control and caseloads as appropriate. The roles of team members are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching to develop their capacities to function as managers and experts in their fields. The organization holds supervisors accountable for communicating organizational goals, as well as for supervision.
- Credentials of staff established by the management team and approved by the Governing Body are contained in the job descriptions. An individual hired into a position has his/her credentials verified through primary source verification and records maintained in the employee's record.

- A record of primary source verification is maintained in the individual employee record. This includes, at a minimum, verification of licensure, review of insurance coverage/liability claims history, history of Medicaid or Medicare licensure, as applicable, verification of board certification for physicians, verification of education and training required by law, and references/performance evaluation/information. Statements about applicant's ability to perform requested privileges/duties are confirmed.
- Staff must have appropriate credentials and meet qualifying standards of the organization. These are updated and checked regularly.
- The organization provides training and training opportunities for all levels of staff.
- Staff is required to participate in training activities on an ongoing basis, as specified by the organization and position and job descriptions.

APPENDIX T

INFORMATION MANAGEMENT GUIDANCE

APPENDIX T

INFORMATION MANAGEMENT GUIDANCE

Specific recommendations regarding Information Management are as follows:

- Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.
 - The organization maintains signed releases for sharing of clinical information
 - Where necessary, signed affiliation agreements exist
 - Reports are available on an appropriate schedule (weekly, bi-weekly, monthly, quarterly, etc.) for use by service providers, case managers, supervisors, managers, CEO, and the Governing Body for assessing client and organizational progress
 - Reports to authorities (state, federal, and other funding and regulatory entities) for review are submitted accurately, in the required formats and on a timely basis
- The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure, in accordance with HIPAA and Rhode Island state law.
 - The organization has policies and procedures in place to safeguard administrative records, case records, and electronic records
 - Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.
- Client information is accessible and is maintained in a consistent and timely manner, with enough information to support the consumer's needs or diagnosis, justify services delivered, and to document a course of treatment and service outcomes

- Every client will have a record that contains: an initial assessment, the detailed assessment of client assets and needs, client goals, care/treatment plan, documentation of care/services provided, documentation of change in client's status, and discharge summary
- All client must include evidence of informed consent, where required
- The client record documents all contacts/interventions provided and results from the interventions. Missed appointments and non-compliance should also be documented. All entries into the client records are dated and authenticated, and follow established policies and procedures. (See Documentation Guidelines for Certified Lead Centers Appendix U)

APPENDIX U

**CERTIFIED LEAD CENTERS DOCUMENTATION
GUIDELINES**

**RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
Center for Child and Family Health**

**Certified Lead Centers
Documentation Guidelines**

RI Department of Human Services
Center for Child and Family Health
Revised July 2006

I. Documentation Requirements

- A. Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to children receiving Certified Lead Center (CLC) services. Providers must furnish to DHS and/or the Medicaid Fraud Control Unit of the Attorney General's Office such records and any other information regarding payments for claimed or services rendered that may be requested. These guidelines are applicable to all children receiving CLC services.

Documentation – The Basics

The following comprise the basic principles of documentation. These principles apply to all types of services in all settings:

1. The service/client record should be complete and legible.
 2. The documentation of each client/consumer encounter should include or provide reference to:
 - The reason for the encounter, and as appropriate, relevant history
 - Current status
 - Written treatment or progress notes including care provided and the setting in which the services were rendered
 - Date and time and legible identity/credentials of care provider
 - The amount of time it took to deliver the services
 3. The Client's progress, response to and changes in treatment and any revision of the treatment plan should be documented.
- B. A clear, consistent documentation trail must be maintained. Each provider is responsible for devising a system that documents all service encounters and contacts. This information is usually contained in the case record, a daily log, or both and must be sufficiently detailed to show the time and effort for case management services provided including the nature and substance of the contact or service.
- C. All CLC services must be provided in accordance with a family-approved Family Care Plan that clearly documents the medical

necessity of the services. Family Care Plans must conform with guidelines in the Certified Lead Centers Certification Standards.

D. Methods of Documentation:

1. Information may be coded on a log, flow sheet, worksheet or computerized record, with regular, periodic summaries, at appropriate intervals, but at least monthly. Information should include the overall relationship of the services to the goals and objectives described in the Family Care Plan with an update describing the client's progress. The case manager's assessment of the effects of the interventions must be recorded.
2. The client's progress and current status in meeting the goals and objectives of the FCP must be regularly recorded in the client record in the form of progress notes.

Progress notes must include:

- a) Documentation of the implementation of the FCP
 - b) Chronological documentation of the client's clinical course
 - c) Significant events and/or changes in the client's status should be documented with a full narrative note as and whenever these occur
 - d) Periodic documentation of all services provided to the client
 - e) Descriptions of the response of the client to services as well as the outcome of interventions (behaviorally described)
3. A closure summary must be entered into the client record within a reasonable period of time after closure.

The Closure Summary must include:

- a) Significant findings including final primary and secondary diagnoses
- b) General observations about the client's condition initially, during treatment and at closure
- c) Whether the closure was planned or unplanned and, if unplanned, the circumstances
- d) Assessment of attainment of the FCP objectives
- e) Documentation of referral(s) to other appropriate programs or agencies

II. Monitoring and Quality Assurance

Site visits will be conducted by DHS staff to monitor appropriate use of Medicaid services and compliance with the procedures outlined in this manual. During these visits, staff will review the following:

- 1.) Client records and treatment plans
- 2.) Staff orientation programs and attendance logs
- 3.) Agency policy and procedures related to service provision
- 4.) Claims information/documentation
- 5.) Staff time sheets
- 6.) Complaint logs

Providers will be notified of DHS site visits in advance if possible. Unannounced site visits may also be conducted at the discretion of the Department. DHS staff may contact or visit families as part of the oversight and monitoring activities.

In the event of adverse findings of a minor nature, repayment to DHS may be required. In situations where, in the opinion of the Department, significant irregularities in billing or utilization are revealed, providers may be required to perform a complete self-audit in addition to making repayments. In either case, technical assistance in developing and implementing a plan of corrective action, where appropriate and applicable, will be offered to the provider.

In addition to monitoring conducted by DHS, providers are subject to periodic fiscal and program audits by the Centers for Medicare and Medicaid (CMS).

RI Department of Human Services

Documentation Guidelines for Certified Lead Center Services

All Certified Lead Center services must be provided in accordance with a comprehensive Family Care Plan that documents the medical necessity for the services. Treatment plans for clients for whom providers are billing Medicaid must conform to the following guidelines:

1. Each client shall have a current written, comprehensive, individualized Family Care Plan that is based on assessments of the client's needs.
2. Responsibility for the overall development and implementation of the Family Care Plan must be assigned to an appropriate member of the professional staff.

3. The Family Care Plan must be reviewed at major decision points in each client's course of case management including:
 - (a) The time of admission and closure
 - (b) A major change in the client's condition
 - (c) The point of the estimated length of services and thereafter based on the estimated length of services, e.g., re-reviews of the FCP
 - (d) At least monthly
4. The Family Care Plan must contain specific goals that the client must achieve and/or maintain as well as maximum growth and adaptive capabilities. These goals must be based on periodic assessments of the client and as appropriate; the client's family, and as agreed to by the family.

Supplemental Guidelines:

1. Medicaid is, by definition, a *medical* program that pays for *medical* services. The Family Care Plan is regarded as a prescription for non-medical case management and coordination of these services with medical management of the lead poisoned child. The FCP must be signed by an appropriate professional and the parent or legal guardian.
2. **The lead poisoning diagnosis must clearly be evident in the Family Care Plan and the diagnosis must be considered as the overall plan is developed.**
3. **The reasons for, and the amount and duration of each specific intervention, should be evident in the FCP.**

Progress notes should reflect ongoing provider assessment regarding the results of the services rendered, i.e., an assessment of why the interventions prescribed are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done.