Virginia Department of Health
Division of Disease Prevention
HIV Care Services
Service Standards: Based on the Health Resources and Services Administration (HRSA) Policy Clarification Notice (PCN) # 16-02[1]

Referral for Health Care/Supportive Services Standards[2]

Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

All service provision will comply with the Department of Health and Human Services (HHS) Guidelines and the Commonwealth of Virginia Department of Health (VDH) Service Standards for persons living with HIV, including the following:

1.0 Intake and Eligibility ***National Monitoring Standards: Documentation that funds are used only: a) to direct a patient to a service in person or through other types of communication; b) to provide benefits/entitlements counseling and referral consistent with HRSA requirements; c) to manage such activities; d) where these services are not provided as a part of Ambulatory/Outpatient medical Care or Case Management services.[3]***
Human Resources and Services Administration (HRSA), the funder for Ryan White HIV Services, prohibits continued HIV services, including medications to clients who are not recertified for eligibility of services by their specified date; therefore, if a client has not

[1] *Policy Clarification Notice (PCN) #16-02* (Revised 10/22/18)
[2] *HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards— Program Part B (April, 2013), p. 41-44*

completed their annual certification or recertification at six months they may not be eligible for Ryan White services.	
Standard	**Measure**
1.1) The client's eligibility for Ryan White Part B services is determined or is in process of determination before services are initiated.	1.1) Documentation of the client's eligibility or that the eligibility process has been initiated and is present in the client's record.
1.2) Client must be recertified annually and recertification must occur every six months to receive Ryan White services. There is no grace period for annual certifications and re certifications.	1.2) Documentation of the client's eligibility or that the eligibility process has been completed both annually and every six months and is present in the client's record.
1.3) A referral by a Ryan White Part B provider is made for initiation of services.	1.3) Documentation of the referral by a Ryan White Part B provider is present in the client's record, signed and dated.
1.4) To be eligible for this service applicants must: a) Be diagnosed with HIV b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Ryan White Part B is the payer of last resort and other funding sources must be vigorously pursued. Providers are responsible to ensure that clients are screened and deemed ineligible for other payer sources covered by Federal or State programs such as Medicare, Medicaid, all other forms of insurance or third party payers such as private and commercial insurance plans, and other payers. e) Provide recertification every six months with proof of income, changes in insurance coverage, or any changes in residency f) **Client eligibility ensures Part B services are used as the payer of last resort.** Client must agree to participate in the insurance option client is eligible and that best meets the client's medical needs regardless of preference. *Note:* The Part B Program is the payer of last resort. This is interpreted as "funds	1.4) Documentation is present in files that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status (gap of services) e) Recertification for continued eligibility for Part B services every six months f) Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

received...will not be utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made..." by another payment source.[i] Apply through the VDH Central Office or through agency's eligibility services.	
2.0 Key Services Components and Activities (include assessment and service plan)	
Standard	**Measure**
2.1) Screening and intake to be completed within 5 days of initial contact with patient.	2.1) Documentation of intake, eligibility screening & needs assessment in patient's record.
2.2) Referral services are not provided as part of Ambulatory/Outpatient Medical Care or Case Management services.	2.2) Documentation of referral services conducted by date of service, type of communication, referral & follow up provided.
2.3) Refer persons who are HIV-positive to medical care within 5 days of intake.	2.3) Documentation with date of persons referred for medical care and/or patient's refusal.
2.4) Determine if referred patients have engaged in medical care within 1 month of referral.	2.4) Documentation of medical visit attendance in patient's record.
2.5) Refer persons who are HIV-positive to appropriate supportive services within 14 days of intake.	2.5) Documentation with date and referral information of persons referred for supportive services and/or patient's refusal.
2.6) Determine if referred patients completed the referral within 1 month of referral.	2.6) Documentation of outcome of referral in patient's record.
2.7) Conduct a reassessment every 90 days to determine additional and/or ongoing needs.	2.7) Documentation of reassessment every 90 days in patient's record.
2.8) **Referral for Health Care services** According to HRSA National Monitoring Standards develop and implement services to direct clients to needed services. Referral services will: • Direct a client to a service in person or through other types of communication	2.8) Documentation of implemented services that directed clients to needed services in patient's record. Documentation of specified mode of communication by client in patient's record.

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Possible modes of communication include telephone, phone, email, and/or text messages
Client must specify which mode(s) of communication is acceptable
Staff must maintain client confidentially in all communications
Provide benefits/entitlements counseling and referral

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<tr><td>2.9) Intake
Staff will conduct an intake within five (5) business days of initial contact with the client to determine eligibility for and need of health care or supportive service referral services.</td><td>2.9) Documentation with date of intake, eligibility screening & identification of needs</td></tr>
<tr><td>2.10) Services Benefits Counseling
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Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services.
It is the primary responsibility of staff to ensure clients are receiving all the benefits/resources for which they are eligible.
Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources
Staff will explore the following as possible options for clients:

AIDS Drug Assistance Program (ADAP)
Health Insurance Premium Payment
Food stamps
Insurance Continuation (COBRA, OBRA, HIPAA)

</td><td>2.10) Documentation of progress of client enrollment into eligible benefits/resources for which they are eligible for and located in client’s file.

Documentation of completed follow-up after 90-days to assess if additional needs or benefits are needed and placed in client’s record.</td></tr>
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• Medicaid • Medicare • Pharmaceutical Patient Assistance Programs (PAPS) • Private Insurance • Health Insurance through Affordable Care Act (ACA) • Social Security Programs • Social Security Disability Insurance (SSDI) • Supplemental Security Income (SSI) • Social Security Retirement State Disability Insurance (SDI) • Temporary Aid to Needy Families (TANF) • Unemployment Insurance (UI) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Worker's Compensation • Other public/private benefits programs. e) Assist clients who are HIV positive with completion of benefits application as appropriate within fourteen (14) business days of referral intake f) Determine if referred patients completed the application process within 30 business days of referral g) Conduct a follow-up within 30 and 90 days of completed application to determine if additional and/or ongoing needs are present	
2.11) **Health Care Services** a) Staff will assist clients in accessing available resources for health care entry	2.11) Documentation of referral made to medical care in client's record.

into and movement through care service systems: • Refer persons who are HIV positive to medical care within five (5) business days of referral intake • Determine if referred patients have engaged in medical care within 30 business days of referral • Refer persons who are HIV positive to appropriate supportive services within fourteen (14) business days of referral intake b) Determine if referred patients completed the referral within 30 business days of referral	
2.12) **Referral** Staff will follow-up on referrals to determine whether the client accessed medical care and/or other services to ensure that they continue receiving said services and to avoid duplication and to prevent client abuse of the care system.	2.12) Documentation of referral follow-up in client's record.
Transition and Discharge	
2.13) Client discharged when Emergency Housing Services are no longer needed, goals have been met, upon death or due to safety issues. (*see 2.14*) Prior to discharge: Reasons for discharge and options for other service provision should be discussed with client. Whenever possible, discussion should occur face-to-face. If not possible, provider should attempt to talk with client via phone. If verbal contact is not possible, a certified letter must be sent to client's last known address. If client is not present to sign for the letter, it must be returned to the provider. Documentation: Client's record must include: a) Date services began b) Special client needs c) Services needed/actions taken, if applicable	2.13) Documentation of discharge plan and summary in client's record with clear rationale for discharge within 30 days of discharge, including certified letter, if applicable.

d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. Transfer: If client transfers to another location, agency or service provider, transferring agency will provide discharge summary and other requested records within 5 business days of request. If client moves to another area, transferring agency will make referral for needed services in the new location. Unable to Locate: If client cannot be located, agency will make and document a minimum of three follow-up attempts on three separate dates (by phone or in person) over a three-month period after first attempt. A certified letter must be mailed to the client's last known mailing address within five business days after the last attempt to notify the client. The letter will state that the case will be closed within 30 days from the date on the letter if an appointment with the provider is not made. Withdrawal from Service: If client reports that services are no longer needed or decides to no longer participate in the Service Plan, client may withdraw from services. Because clients may withdraw for a variety of reasons it may be helpful to conduct an exit interview to ensure reasons for withdrawal are understood, or identify factors interfering with the client's ability to fully participate if services are still needed. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Clients who engage in behavior that abuses the safety or violates the confidentiality of others may be discharged. Prior to discharging a client for this reason, the case must be reviewed by leadership according to that agency's policies. Clients who are discharged for administrative reasons must be provided written notification of and reason for the discharge, and must be	

notified of possible alternative resources. A certified letter that notes the reason for discharge and includes alternative resources must be mailed to the client's last known mailing address within five business days after the date of discharge, and a copy must be filed in the client's chart.	
Case Closure	
2.14) Case will be closed if client: a) Has met the service goals; b) Decides to transfer to another agency; c) Needs are more appropriately addressed in other programs; d) Moves out of state; e) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; f) Fails to maintain contact with the housing assistance staff for a period of three months despite three (3) documented attempts to contact client; g) Can no longer be located; h) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; i) Exhibits pattern of abuse as defined by agency's policy. j) Becomes housed in an "institutional" program anticipated to last for a minimum of 30 days, such as a nursing home, prison or inpatient program; or k) Is deceased.	2.14) Documentation of case closure in client's record with clear rationale for closure.
3.0 Client Rights and Responsibilities *National Monitoring Standards: Provision of Part B funded HIV primary medical care and support services, to the maximum extent, without regard to either: the ability of the individual to pay for such services, or the current or past health conditions of the individuals served.*[ii]	
Standard	**Measure**

3.1) Services are available and accessible to any individual who meets program eligibility requirements. All providers shall be in compliance with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the American's with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering services on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or HIV/AIDS diagnosis. Each provider shall make available to clients a process for requesting interpretation services, including American Sign Language.	3.1) Written eligibility requirements and non-discrimination policy on file.
3.2) Clients Rights and Responsibilities policy exists which requires each client to sign & date a form indicating they has been offered: a) explanation of the policy, and b) copy of *'Client's Rights and Responsibilities* and to communicate client's understanding of the policy.	3.2) Written policy on file.
3.3) Explanation of *Client's Rights and Responsibilities* is provided to each client. Client rights include: o Be treated with respect, dignity, consideration, and compassion; o Receive services free of discrimination; o Be informed about services and options available. o Participate in creating a plan of services; o Reach an agreement about the frequency of contact the client will have either in person or over the phone. o File a grievance about services received or denied; o Not be subjected to physical, sexual, verbal and/or emotional abuse or threats;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.

o Voluntary withdraw from the program; o Have all records be treated confidentially; Have information released only when: o A written release of information is signed; o A medical emergency exists; o There is an immediate danger to the client or others; o There is possible child or elder abuse; or o Ordered by a court of law. Client responsibilities include: o Treat other clients and staff with respect and courtesy; o Protect the confidentiality of other clients; o Participate in creating a plan of service; o Let the agency know any concerns or changes in needs; o Make and keep appointments, or when possible, phone to cancel or change an appointment time; o Stay in contact with the agency by informing the agency of change in address and phone number, responding to phone calls and mail o Avoid subjecting the agency's staff to physical, sexual, verbal and/or emotional abuse or threats.	

4.0 Grievance Process

Standard	Measure
4.1) Grievance policy exists which requires each client to sign & date form indicating they has been offered: a) explanation of the policy, and b) copy of *Grievance Procedure* and c) communication of client's understanding of the policy. Policy shall describe the process for resolving client grievances, including identification of whom to contact and applicable timelines.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.

Policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to populations served.	
4.2) Explanation of *Grievance Procedure* is provided to each client. Clients may file a grievance if their request for services is denied or if they have any complaint or concern about the services received.	4.2) Current *Grievance Procedure* form signed and dated by Client and located in client's record.
4.3) Grievance process shall be fair and expeditious for resolution of client grievances.	4.3) Documentation of client grievances, status and resolution.
4.4) Review of the grievance policy yearly with client signature.	4.4) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record.

5.0 Personnel Qualifications (including licensure)
National Monitoring Standards: Referrals may be made: a) within the non-medical case management system by professional case managers; b) informally through community health works or support staff; c) as part of an outreach program.[4]

Standard	Measure
5.1) Referral staff must have a high school diploma or GED and one year of experience working with patients infected with HIV or additional health care training.	5.1) Documentation of qualifications in personnel file.
5.2) Newly employed referral staff must complete the following training within 180 calendar days of hire: • HIV 101 • Cultural competency • Counseling and Referral.	5.2) Documentation of training completed in personnel file.
5.3) Referral staff must complete six (6) hours of continuing education on HIV/AIDS annually.	5.3) Documentation of continuing education credits in personnel file.
5.4) **Staff Qualifications** Staff should be knowledgeable and experienced regarding referral services and the HIV continuum of care.	5.4) Documentation reflecting knowledge and skills in the staff personnel file.

[4] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), pp. 44-44.

Staff and volunteers who provide referral services shall possess the following: • Knowledge about and experience working with underserved populations • Knowledge of and ability to effectively utilize interviewing, assessment and presentation skills and techniques in working with a wide variety of people • Knowledge of community resources available to eligible persons so that appropriate effective referrals can be made • Skills and experience necessary to work with a variety of HIV/AIDS service providers, including other referral staff, case managers and interdisciplinary personnel and directs who are culturally and linguistically diverse.	
5.5) **Staff Education** a) Within the first three (3) months of hire, training for new staff and volunteers shall include but not limited to: • Specific HIV-related issues • Substance abuse and treatment • Mental health issues • Domestic violence • Sexually transmitted diseases • Partner notification • Housing Services • Adolescent health issues • Commercial sex workers • Incarcerated/recently released • Gay/lesbian/bisexual/trans-gender concerns. b) Continuum of care for HIV+ persons including the process of referring a client to a medical intake site • Safety protocols for staff and volunteers governing the	5.5) Personnel records will reflect completion of training.

manner in which referral services will be provided • Staff has knowledge of local resources. c) Ongoing training for staff must be provided to appropriate staff to maintain current knowledge about outreach, including information about advances in medical care and treatment of PLWH. d) Personnel records will reflect completion of training.	
5.6) **Supervision** a) All non-professional staff must be supervised by a degreed or licensed individual in the fields of health, social services, mental health or possess equivalent experience b) Supervisors must review a sample of ten percent (10%) of each staff member's client records each month for completeness, compliance with these standards, and quality and timeliness of service delivery c) Each supervisor must maintain a file on each staff member supervised and hold supervisory sessions at least monthly.	5.6) Results of the supervisory review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.

6.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
6.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	6.1) Written client confidentiality policy on file at provider agency.
6.2) Client's consent for release of information is determined.	6.2) Current *Release of Information Form* signed and dated by client and provider representative and located in client's record. Each release form indicates who may receive the client's information and has an expiration of not more than 12 months from date of signature.

6.3) Each client file is stored in a secure location. Electronic client records are protected from unauthorized use.	6.3) Files stored in locked file or cabinet with access limited to appropriate personnel. Electronic files are secure with password protection and access is limited to appropriate personnel.
6.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	6.4) Documentation of signed ***Verification of Receipt of Assurance of Key Requirement*** **forms.**

7.0 Quality Management ***National Monitoring Standards: Implement a Clinical Quality Management Program (CQM) to include: a) written QM plan; b) quality expectations for providers and services; c) method to report and track expected outcomes; d) monitoring of provider compliance with HHS treatment guidelines and Part B Program's approved Standards of Care.***	
Standard	**Measure**
7.1) Measure and report client health outcomes using referral for Health Care/Supportive Services measures approved by VDH.	7.1) Performance measurement data on the following indicators: • Percentage of people enrolled in RW Part B-funded Program living with HIV regardless of age and receiving Health Care/Supportive Services, who will have at least one care markers in a 30 days period (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date). • Percentage of persons living with HIV and receiving referral for Health Care/Supportive Services, regardless of age, who will have at least two care markers in a 12 month period that are at least 3 months apart (Care marker defined as evidence of a HIV medical care visit date, a CD4 count and test date, a viral load value and test date, and/or an antiretroviral medication prescription and date).

[i] Public Health Service Act; Sections 2605(a)(6), 2617 (b) (7) (F), 2664 (f) (1), and 2671 (i).

[ii] HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards—Program Part B (April, 2013), pp. 61-62.