Referral for Health Care/Supportive Services Standards

Description from the Health Resources and Services Administration (HRSA) Policy Clarification Notice 16-02:
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. Activities provided under this service category may include referrals to assist HRSA RWHAP-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).

Virginia Ryan White Part B Service Unit Definition:
One 15-minute encounter.

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 with HIV, including the following:

1.0 Intake and Eligibility
As outlined in HRSA HAB Policy Clarification Notice 21-02 Clarifications (PCN) on Ryan White Program Client Eligibility Determinations and Recertification Requirements, people are eligible to receive RWHAP services when they meet each of the following factors:

1. **HIV Status:** A documented diagnosis of HIV. (Note: People who do not have an HIV diagnosis are eligible to receive certain services as outlined in HRSA HAB PCN 16-02

2. **Low- Income:** The RWHAP recipient defines low-income. Low-income may be determined based on percent of Federal Poverty Level (FPL), which can be measured in several ways (e.g., Modified Adjusted Gross Income, Adjusted Gross Income, Individual Annual Gross Income, and Household Annual Gross Income).

3. Residency: The RWHAP recipient defines its residency criteria, within its service area. Note: Immigration status is irrelevant for the purposes of eligibility for RWHAP services. RWHAP recipients or subrecipients should not share immigration status with immigration enforcement agencies.

Standard	Measure
Referral	
1.1) Self-referral or referral by a Part B provider for Referral for Health Care/Supportive Services is documented prior to initiation of the service.	1.1) Appointment documented to attend Referral for Health Care/Supportive Services is present in the client's record.
Eligibility	
1.2) The client's eligibility for Ryan White Part B services is determined. To be eligible for this service applicants must: a) Be diagnosed with HIV (one time only) b) Live in Virginia c) Have an individual or family income at or below 500% of the Federal Poverty Level (FPL) d) Be 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 that provide the service they are seeking. • Client Access Reviews (CARs) - refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility. • Provide continuation of eligibility every 24 months with proof of income, changes in insurance coverage, or any changes in residency • Client eligibility ensures Part B services are used as the payer of last resort and other funding sources must be vigorously pursued**.** Client must agree to participate in the insurance option that the client is eligible for and	1.2) Documentation of the client's eligibility is present in the client's record that verifies: a) Client is diagnosed with HIV b) Client lives in Virginia c) Client meets income guidelines d) Client Medicaid status verified (gap of services) • Ongoing CARS and complete Continuation Eligibility Determination every 24 months • Client agrees to participate in insurance option that best meets their medical needs and for which the client is eligible.

that best meets the client's medical needs regardless of preference. Submission of eligibility assessments should be through the Provide Enterprise® data system.	
Intake	
1.3) Complete eligibility screening and intake within 15 days of initial contact with client.	1.3) Documentation of intake and eligibility screening in record signed and dated.
Client Access Reviews/Continuation of Eligibility	
1.4) Client Access Reviews (CARs) refer to periodic checks of enrolled RWHAP B clients to identify any potential changes that may affect eligibility and continuation of eligibility conducted every 24 months to continue to receive Ryan White services. There is no grace period.	1.4) Documentation of CARS and continuation of eligibility is present in the client's record.
2.0 Key Services Components and Activities	
Documentation	
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 • 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	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.
Assessment/Provision of Services	
2.9) 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.	2.9) Documentation with date of intake, eligibility screening & identification of needs
2.10) For Services Benefits Counseling: a) Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. b) It is the primary responsibility of staff to ensure clients are receiving all the benefits/resources for which they are eligible. c) Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with recertifications,	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.

and provide advocacy in other areas relevant to maintaining benefits/resources d) 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) • 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) Staff will assist clients in accessing available resources for health care entry 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 • Determine if referred patients completed the referral within 30 business days of referral.	2.11) Documentation of referral made to medical care in client's record.
2.12) 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*) <u>Prior to discharge</u>: Conduct discussion with client over reasons for discharge and options for other service provisions. 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	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. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff, that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*

present to sign for the letter, return to the provider. **Exception: If the client has noted during the intake or at any other time to the VA MAP staff that sending mail is not permitted, no letter will be sent. If this is the case, VDH will document this in progress notes and discharge summary.* <u>Documentation:</u> Client's record must include: a) Date services start b) Special client needs c) Services needed/actions taken, if applicable d) Date of discharge e) Reason(s) for discharge f) Referrals made at time of discharge, if applicable. <u>Transfer:</u> If client transfers to another location (state), 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. <u>Unable to Locate:</u> 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. The three attempts should start no later than three months prior to the due date. 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 case closure within 30 days from the date on the letter if no appointment is schedule with the provider. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in*	

progress notes and discharge summary. Withdrawal from Service: If client reports no longer needing services 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 understanding reasons for withdrawal, or if client still needs services identify factors interfering with the client's ability to fully participate. If other issues are identified that cannot be managed by the agency clients should be referred to appropriate agencies. Administrative Discharge: Discharge clients who engage in behavior that abuses the safety or violates the confidentiality of others. Prior to discharging a client for this reason, agency leadership according to that agency's policies must review the case. Provide clients discharged for administrative reasons written notification of and reason for the discharge and notify 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. **Exception: If the client has noted during the intake or at any other time to the subrecipient staff that sending mail is not permitted, no letter will be sent. If this is the case, case managers will document this in progress notes and discharge summary.*	
Case Closure	
2.14) Case will be closed if client: a) Has met the service goals; b) No longer meets eligibility criteria; c) Decides to transfer to another agency;	2.14) Documentation of case closure in client's record with clear rationale for closure.

d) Needs are more appropriately addressed in other programs; e) Moves out of state; f) Fails to provide updated documentation of eligibility status thus, no longer eligible for services; g) Fails to maintain contact with the ADAP staff for a period of three months despite three (3) documented attempts to contact client; h) Can no longer be located; i) Withdraws from or refuses funded services, reports that services are no longer needed, or no longer participates in the individual service plan; j) Exhibits pattern of abuse as defined by agency's policy. k) 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 l) Is deceased.	
3.0 Client Rights and Responsibilities	
Standard	**Measure**

3.1) Services are available and accessible to any individual who meets program eligibility requirements. Each provider shall assist clients with conducting Ryan White Part B eligibility, regardless of whether they receive other Part B services at your agency. All providers shall comply with all applicable federal, state, and local anti-discrimination laws and regulations, including but not limited to the Americans with Disabilities Act. All providers shall adopt a non-discrimination policy prohibiting the refusal of rendering any service because of 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) Each agency should have a Client's Rights and Responsibilities policy, which requires each client to sign & date a form indicating they have 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) Provide explanation of *Client's Rights and Responsibilities* to each client. Client rights include: • Be treated with respect, dignity, consideration, and compassion; • Receive services free of discrimination; • Be informed about services and options available. • Participate in creating a plan of services;	3.3) Current *Client's Rights and Responsibilities* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the rights and responsibilities.

• Reach an agreement about the frequency of contact the client will have either in person or over the phone. • File a grievance about services received or denied; • Not be subjected to physical, sexual, verbal and/or emotional abuse or threats; • Voluntary withdraw from the program; • Have all records be treated confidentially; Have information released only when: • A written release of information is signed; • A medical emergency exists; • There is an immediate danger to the client or others; • There is possible child or elder abuse; or • Ordered by a court of law. **Client responsibilities include:** • Treat other clients and staff with respect and courtesy; • Protect the confidentiality of other clients; • Participate in creating a plan of service; • Let the agency know any concerns or changes in needs; • Make and keep appointments, or when possible, phone to cancel or change an appointment time; • Stay in contact with the agency by informing the agency of change in address and phone number; respond to phone calls and mail and • 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 requires each client to sign & date indicating they have been offered: a) explanation of the policy, 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. Policy shall be available in languages and formats (e.g., for persons with disabilities) appropriate to populations served.	4.1) Written grievance procedure on file, available in languages and formats appropriate to populations served.
4.2) Provide explanation of *Grievance Procedure* to each client. Clients may file a grievance if denied their request for services, 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. If client unable to sign, progress note should include documentation the client has received a copy of the grievance procedure.
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 *Grievance Procedure* form signed and dated by client and located in client's record. If client unable to sign, progress note should include documentation the client has received a copy of the client's grievance procedure.
5.0 Personnel Qualifications (including licensure)	
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	5.2) Documentation of training completed in personnel file.

• Counseling and Referral.	
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 should be knowledgeable and experienced regarding referral services and the HIV Continuum of Care. 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.	5.4) Documentation reflecting knowledge and skills in the staff personnel file.
5.5) 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.	5.5) Documentation of training completed in personnel file.

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 way 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 PWH. d) Personnel records will reflect completion of training.	
5.6) 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. • 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. • 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 Cultural and Linguistic Competency	
Standard	**Measure**
6.1) Referral services are culturally and linguistically competent, client-guided and community based. At a minimum, documentation should include: a) Experience with providing services to the diverse ethnic, linguistic, sexual, or cultural populations targeted;	6.1) Documentation of cultural and linguistic competence as reported in annual Cultural and Linguistic Competency Report.

b) Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; c) List of cultural competency trainings completed by staff.	
6.2) Easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area shall be available.	6.2) Culturally and linguistically appropriate materials and signage accessible.
7.0 Privacy and Confidentiality (including securing records)	
Standard	**Measure**
7.1) Client confidentiality policy exists which include: a) Release of information requirements, and b) Health Insurance Portability and Accountability Act.	7.1) Written client confidentiality policy on file at provider agency.
7.2) Client's consent for release of information is determined.	7.2) 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.
7.3) Each client file is stored in a secure location. Electronic client records are protected from unauthorized use.	7.3) 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.
7.4) Annual submission of *Verification of Receipt of Assurance of Key Requirements* document by all staff that handle client identifying information.	7.4) Documentation of signed *Verification of Receipt of Assurance of Key Requirement* forms.

8.0 Quality Management	
Standard	**Measure**
8.1) Measure and report client health outcomes using referral for Health Care/Supportive Services measures approved by VDH.	8.1) Performance measurement data on the following indicators: • Percentage of people enrolled in RW Part B-funded Program with HIV regardless of age and receiving Health Care/Supportive Services, who will have at least one care markers in a 30-day period (Care marker defined as evidence of an 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 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 an 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).

References

HRSA HAB Policy Clarification Notice 16–02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds. (2018, October 22). HRSA Ryan White HIV/AIDS Program. Retrieved August 18, 2022, from https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

HRSA HAB Policy Clarification Notice 21–02 Clarifications on Ryan White Program Client Eligibility Determinations and Recertification Requirements. (2021, October 18). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/pcn-21-02-determining-eligibility-polr.pdf

Monitoring Standards for Ryan White B Grantees: Fiscal – Part B. (2013, April). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/fiscal-monitoring-partb.pdf

National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B. (2013, April). HRSA Ryan White HIV/AIDS Program. Retrieved August 19, 2022, from https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/universal-monitoring-partab.pdf