HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Section 11 – Quality Advisory Committee

SECTION	SECTION / POLICY TITLE	CURRENT VERSION	PREVIOUS REVISIONS
11	**SERVICE STANDARDS COMMITTEE**		
	Universal Service Standards	6/27/18	N/A
	SSC 01 – Medical Case Management Services	12/11/19	4/25/18, 3/25/15, 4/8/10 1/26/05, 7/25/01
	SSC 02 – Respite Services	6/27/18	4/27/16, 3/25/15, 7/22/98
	SSC 03 – Dental Services	6/27/18	4/27/16, 3/25/15, 6/2/10, 12/10/08, 6/22/05, 6/98
	SSC 04 – Support Services	4/25/18	4/27/16, 3/25/15, 12/98
	SSC 05 – Eligibility and Fees	6/27/18	4/27/16, 3/25/15, 1/23/13, 8/24/11, 5/5/10, 12/10/08, 5/24/06,7/23/03, 1/22/03, 9/27/00
	SSC 06 – Substance Abuse Treatment Services	4/27/16	12/8/10, 7/23/03, 7/26/00
	SSC 07 – General Policy Directives for Ryan White Part A/B Services	Inactive	9/27/00
	SSC 08 - Child Care Services	4/27/16	1/26/11, 5/24/06, 7/23/03
	SSC 09 - General Policy Directives for Apportionment of Ryan White Part A/B Funding	Inactive	3/28/01

	SSC 10 – Utilities Assistance Services	4/27/16	1/26/11, 5/24/06, 7/23/03
	SSC 11 – Medical Transportation Services	4/27/16	5/5/10, 7/23/03
	SSC 12 – Food and Nutritional Services	4/27/16	12/8/10, 09/27/06, 1/22/03
	SSC 13 – Complementary/Alternative Therapies Services	Inactive - 4/27/11	1/22/03
	SSC 14 – Mental Health Services	07/26/16	01/26/11, 12/13/06
	SSC 15 – Housing Assistance Services	02/27/17	12/08/10, 5/26/04
	SSC 16 – Other Critical Need Services	02/27/17	04/27/11, 5/26/04
	SSC 17 – Support Group Services	04/26/17	01/26/11, 12/4/04
	SSC 18 - Medical Nutritional Therapy	04/26/17	09/22/10
	SSC 19 – Outreach Services	06/28/17	12/08/10
	SSC 20 – Health Education and Risk Reduction	03/28/18	12/08/10
	SSC 21 – Social Services Case Management	12/12/12	N/A
	SSC 22 – Health Insurance Premium and Cost – Sharing Assistance	03/28/18	04/27/16, 9/24/14

HIV Health Services Planning Council
Sacramento TGA

UNIVERSAL SERVICE STANDARDS

Date Approved: 06/26/18
Date Revised:
Date Reviewed:

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Universal Service Standards will apply to all Ryan White contracted subrecipients.

1.0 Intake and Eligibility		
Standard	**Measure**	**Responsibility**
1.1 Clients actively enrolled in Ryan White funded services.	1.1 Documentation in client record or an active referral for service on file.	1.1 Subrecipient
1.2 Eligibility criteria must be verified and documented, including: a. HIV-positive status b. Resident of Sacramento TGA c. Income not greater than current service caps and limitations (PCN #13-02 person must be low-income to receive RW services) d. Insurance status	1.2 Documentation in client record or an active referral for service on file.	1.2 Subrecipient
1.3 Agency will notify clients, related agencies, and Recipient of current services, caps, and eligibility restrictions.	1.3 Procedure to ensure distribution of completed Service Matrix or equivalent to clients, related agencies and Recipient in place.	1.3 Subrecipient
1.4 Agency will ensure documentation of client demographic information including unique identifier, name, DOB, SSN, race, ethnicity, gender, mode of transmission, HIV status, current address, income, insurance sources, and evidence of care as defined by Recipient.	1.4 Documentation of client level data will be found in each client file.	1.4 Subrecipient

1.5 Agency will ensure client signs and receives copies of the Client's Rights and Responsibilities, ARIES Share Form, Release of Information, Grievance Procedure and other required program documentation.	1.5 Documentation in client file.	1.5 Subrecipient

2.0 Key Services Components and Activities		
Standard	**Measure**	**Responsibility**
2.1 Agency has a Drug-Free Workplace policy.	2.1 Written drug-free workplace policy on file.	2.1 Subrecipient
2.2 Agency has a policy of non-discrimination in regards to hiring and service delivery.	2.2 Written non-discrimination policy on file.	2.2 Subrecipient
2.3 Agency has a process in place for the recapture of funds when other payer sources are identified or client eligibility has changed.	2.4 Written policy on file.	2.3 Subrecipient
2.4 Subrecipient has policy for regularly scheduled performance evaluations.	2.4 Documentation of evaluations on file.	2.4 Subrecipient
2.5 Agency will have a procedure to make linkages to other Ryan White services or other community services.	2.5 Description of process and examples of referrals made.	2.5 Subrecipient
2.6 Agency will notify clients of current services, caps, and eligibility restrictions.	2.6 Procedure to ensure distribution of completed Service Matrix or equivalent to clients.	2.6 Subrecipient
2.7 Agency will notify clients of any recipient approved changes to current program benefits prior to implementation**.**	2.7 Communicate changes sent to clients regarding program benefits will be on file.	2.7 Subrecipient
2.8 Agency will ensure appropriate staff receives initial training and ongoing education regarding the use of the SHARE database.	2.8 Proof of User IT Agreements; Client intake manual available at worksite.	2.8 Subrecipient

3.0 Personnel Qualifications *(Including licensure)*		
Standard	**Measure**	**Responsibility**
3.1 Staff has the minimum qualifications, including licenses, certifications, and/or training expected and other experience related to the position.	3.1 Resumes, licensures, certificates, or documentation of training and orientations will be in personnel file.	3.1 Subrecipient
3.2 All staff shall receive training and education to build knowledge of HIV/AIDS, including co-occurring conditions and the continuum of care for people living with HIV/AIDS.	3.2 Documentation of trainings completed and/or educational materials reviewed on an annual basis.	3.2 Subrecipient

4.0 Assessment and Service Plan		
Standard	**Measure**	**Responsibility**
4.1 Within 30 days of initial client contact, clients will be assessed using an acuity scale.	4.1 Documentation in client file.	4.2 Subrecipient
4.2 Within 30 days of initial client contact, a Care Plan, Individual Service Plan, or other "planning" document, signed by the client, will be completed identifying goals, objectives and a timeline, to address the client's needs.	4.2 Documentation of Care Plan or Individual Service Plan in client file.	4.2 Subrecipient
4.3 Six-month reassessment of the client's level of care needs using an acuity scale.	4.3 Documentation in Client File.	4.4 Subrecipient
4.4 Clear documentation of client outcomes in the Client Plan of Care, Individual Service Plan, or other "planning" document with revisions, a *minimum* of every six months, reflective of changing client needs.	4.4 Documentation in Client File.	4.5 Subrecipient

5.0 Case Closure and Transfer or Discharge Protocol		
Standard	**Measure**	**Responsibility**
5.1 Sub-recipient has a procedure in place to guide transfer of client or case closure.	5.1 Documentation in case file of reason for discharge, notification of client and appeals process.	5.1 Subrecipient

6.0 Client Rights and Responsibilities		
Standard	**Measure**	**Responsibility**
6.1 Agency has written policies outlining Client Rights and Responsibilities.	6.1 Documentation of Clients Rights & Responsibilities Policy signed by client.	6.1 Subrecipient
6.2 Agency will accommodate special needs clients as specified by the Americans with Disabilities Act guidelines. www.ada.gov.	6.2 Agency will provide documentation of any requests made and how request was accommodated.	6.2 Subrecipient

7.0 Grievance Process		
Standard	**Measure**	**Responsibility**
7.1 Sub-recipient Policy and Procedure for grievances.	7.1 Agency Written Policy and Procedure.	7.1 Subrecipient
7.2 Grievance Procedure visibly posted in client areas.	7.2 Posted Grievance Procedure.	7.2 Subrecipient
7.3 Client Signs Acknowledgment of Grievance Process.	7.3 Documentation in client file signed by client.	7.3 Subrecipient

8.0 Cultural and Linguistic Competency		
Standard	**Measure**	**Responsibility**
8.1 Staff providing direct services to clients shall receive training and education to build cultural competence.	8.1 Documentation of trainings completed and/or educational materials reviewed on an annual basis.	8.1 Subrecipient
8.2 Clients with language barriers will have access to language appropriate resources and services.	8.2 Staff will have resources available in the primary language used by their clients or will have a contact list for obtaining linguistically appropriate resources and services for their clients.	8.2 Subrecipient

9.0 Privacy and Confidentiality (*including securing records)*		
Standard	**Measure**	**Responsibility**
9.1.a. Agency will develop, implement, maintain and use, at its own expense, such appropriate administrative, technical and physical safeguards as may be required to protect client confidentiality. 1. Confidentiality policy exists. 2. Data privacy practices such as encryption, passwords, screen savers, shared network drives or other mechanisms will be used. 3. Client records will be stored in a secure and confidential location.	9.1a. 1. Written policy on file. 2. Written policy on file. 3. All records will be double lock protected with access limited to appropriate personnel.	9.1. Subrecipient

9.1.b. Maintain compliance with HIPAA and or HIV Confidentiality Laws, preserve integrity and confidentiality, and prevent disclosure of personal health information. A release of information will be signed by the client prior to exchange information with other providers.	b. Written HIPAA policy and standardized release form(s) on file.	9.1.b. Subrecipient
9.2 Agency will provide a confidential meeting space.	9.2 Review of confidential space.	9.2 Recipient/ Subrecipient
9.3 Agency will ensure client there is a valid Release of Information on file for each client.	9.3 Documentation in client file signed by client.	9.3 Subrecipient

10.0 Recertification Requirements		
Standard	**Measure**	**Responsibility**
10.1 Each client shall be recertified every six months or sooner if there has been a change in the client's eligibility. Recertification may be done by self-attestation. At least once every 12 months, the recertification procedures shall include an in-depth collection of supporting documentation, i.e., pay stubs, proof of residency, etc., similar to that collected at the initial eligibility determination.	10.1 Documentation in client file.	10.1 Subrecipient

Signed: _____ Date: 06/27/18

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Medical Case Management Service Standards for Persons Living with HIV/AIDS

No.: SSC 01
Date Approved: 07/25/01
Last Revised: 12/11/19
Date Reviewed: 12/11/19

Reference: Ryan White CARE Act Part A Manual SEC. 1.
Action taken by the Affected Communities Committee on May 29, 2001; the Executive Committee on June 19, 2001 and July 13, 2001; and the HIV Health Services Planning Council on July 25, 2001.

Policy: This document details the standards of medical case management required to be carried out by service providers funded by the Sacramento TGA's Ryan White CARE Program. These standards are to be applied in conjunction with other service standards for medical, psychosocial and support care for Ryan White eligible clients as developed and approved by the HIV Health Services Planning Council.

PURPOSE OF MEDICAL CASE MANAGEMENT

The Health Resources Services Administration (HRSA) defines medical case management as:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be delivered by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication).

Required Care Objectives include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a medical case manager;
- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan at the initial assessment, including client-centered goals and milestones;
- Timely and coordinated access to medically appropriate levels of healthcare and support services based on clinical and acuity status of the client;
- Routine client monitoring to determine the efficacy of the care plan;

- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems;
- Treatment adherence counseling to ensure that the client is ready for and adheres to HIV treatments;
- Client-specific advocacy and/or review of service utilization as appropriate; and
- Benefits counseling whereby staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible including but not limited to; Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, Housing Opportunities for Persons with AIDS (HOPWA), and/or other state or local health care and supportive services.

PRINCIPLES OF MEDICAL CASE MANAGEMENT

Medical case management is carried out in a manner that is:

- Participatory in that the medical case manager will engage the client in informed decision making to establish a client-optimized individual plan of care.
- Empowering to clients in developing constructive lifestyles and life choices that will facilitate routine medical care by eliminating barriers to care or other factors that impede optimal function of the client.
- Goal-oriented in the development of the client care plan in order to assess progress and effectiveness of medical case management.
- Flexible in response to the client's immediate, emerging, or otherwise changing needs.
- Culturally proficient in terms and contexts that are understandable and account for the client's personal situation/environment.
- Efficient in design for the purpose of optimizing client specific services based upon need.
- Cost-effective by facilitating the use of resources that will effectively prevent the client from having to access more expensive alternatives.
- Accessible through planned multiple access regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.

- Proactive in will anticipatory referrals to provider services and other supportive resources that most closely match client needs.

FUNCTIONS OF MEDICAL CASE MANAGEMENT

Primary objective is to improve health care outcomes for clients afflicted with HIV or associated conditions.

Required objectives:

- Offer accurate and current information to the client;
- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions;
- Present options to the client from which he/she may select a course of action;
- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm; and
- Be available to support and problem solve and to not judge the client in the present or future based upon their decision(s) of the past;
- Gather and evaluate information from the client;
- In participation with the client, create a care plan that addresses basic living needs, medical treatment and compliance issues, and other appropriate social service needs;
- Promote coordinate and collaborative communication between clients and all persons involved in the client's care.
- Educate the client on available resources and assist them in accessing those resources.
- Reinforce treatment adherence counseling to ensure readiness for the complex HIV/AIDS regiments, coordination of service and monitoring plan.

EDUCATION REQUIREMENTS FOR DESIGNATIONAS MEDICAL CASE MANAGER

Minimum Qualifications
Possession of any health or human services bachelor's degree from an accredited college or university in social work, counseling, psychology, gerontology or licensing/certification as a Nurse Practitioner (NP), Physician Assistant, Public Health Nurse, Registered Nurse or Clinical Pharmacist.

Experience in specialty case management meeting the criteria described below may be substituted for credentialing.

- Full time work in case management activities with direct consumer interaction for a period of no less than three (3) years under the supervision of a health or human services professional

- Individuals without active credentialing or license in their field must receive clinical oversight and supervision by a licensed clinician monthly or more frequently as appropriate.

Training

All staff designated as a Medical Case Manager and those staff providing affiliate case management services must complete an initial training session specific to providing and coordinating service to HIV afflicted individuals Training is be completed within 60 days of hire covering at minimum the following topics:

- General HIV knowledge, such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local HIV system of care including ADAP and HOPWA
- Basic case management skills
- Regional health and human services availability within the TGA
- Trauma Informed Care
- Optional topics may include Motivational Interviewing

The above required training does not preclude a contracted Ryan White employer from determining or otherwise administering additional employer-based training to the provider's work force as appropriate and necessary or attendance at ongoing Medical Case Management training opportunities organized by the Fiscal Agent.

MEDICAL CASE MANAGEMENT PROCESS

Medical Case Management must be delivered in a manner that mitigates barriers to accessing effective care while maximizing available resources to support positive health outcomes for enrolled or potential clients. All Medical Case Management services must include, the functions identified in the Purpose of Medical Case Management Required Care Objectives found in this document.

Process standards are identified and addressed in the following areas:

- Intake
- Assessment

- Reassessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Transfer and Discharge
- Evaluation of Client Satisfaction

Intake

All Medical Case Management services shall be provided in a culturally and/or linguistically competent manner, which is respectful to the client's cultural health beliefs, practices and preferred language.

Each prospective client who requests or is referred for medical case management services will be evaluated through a face-to-face interaction designed to gather information for immediate and future service needs and facilitate informed client decision-making. The service request/referral will be screened for basic admission criteria and assesses whether the client is in a crisis situation and/or requires immediate direct service referral. If immediate intervention is needed, a referral will be expedited to an appropriate entity.

Required intake activity processes are outlined below:

- the Ryan White Program Intake form will be completed in its entirety
- the client will be assessed with an Acuity scale which will be dated and signed by the medical case manager. The acuity scale will be updated every six months for medical case management clients
- the client's Informed Consent to Participate in the medical case management program shall be obtained
- the client will be informed of their right to confidentiality and information privacy procedures
- the client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities
- release of information form must be updated annually.
- the client will be informed of, and agree to the Client's Rights and Responsibilities form
- the client will be informed of the agencies' as well as the Ryan White Program's Grievance Procedure
- the client will be informed of the role and purpose of medical case management

- anticipating basic eligibility, the client may proceed to formal assessment, or be referred to another case management agency (if the client would be better served based upon their particular need for medical or non-medical case management services)

- create a client file and archive all relevant documents and forms

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services.

Assessment

Required assessment process and criteria:

- initial Medical Case Management face-to-face appointments must occur no later than 10 calendar days from the date of referral

- service agency must have in place a process to ensure timely follow-up of no show clients preferably within 24hours

- clients ineligible for Medical Case Management must be referred to an appropriate alternate support service through a warm hand off process

- the Medical Case Manager must complete an in-person psychosocial needs assessment within 30 days of the start of Medical Case Management

- assessment base line will encompass client functional status, strength/weaknesses inventory, stressor points and available resources and future resource needs

- every attempt should be made to develop a complete history for the purpose of care planning recognizing that the client has the right to refuse disclosure and may request deferment of certain information gathering

Assessment content should address:

- Primary care connection;
- Connection with other care providers (e.g. dentist, specialists, key social services)
- Current health status / medical history, including last and next medical appointment, most recent CD4 and VL, and any reasons for terminating care (if applicable);
- Oral health and vision needs
- Current medications / adherence;
- Immediate health concerns;
- Substance use history;
- Mental health / psychiatric history;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Treatment adherence history, including assessment of ability to be retained in care;
- Self-management skills and history;
- Prevention and risk reduction issues;
- History of incarceration
- Family composition;
- Living situation;
- Languages spoken;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Transportation needs;
- Legal issues
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Nutritional status assessment;
- Partner Services needs;
- Cultural issues, including ethnic, spiritual, etc.; and,
- Summary of unmet needs.

CARE PLAN DEVELOPMENT AND IMPLIMENTATION

Required process and components of care plan formulation:

- development is based on an approved acuity scale
- includes any CD4 count and/or viral load tests during the measurement year

- all medical provider visits will be documented as part of the care plan progress note and those visits client self-reported will be verified by the medical case manager inclusive of date through direct contact with the provider, transcript of case conference notes or other corroborating documentation as appropriate.
- individualized holistic with emphasis on medical needs

- includes realistic, measurable goals that are time framed and consistent with ongoing inter-professional assessment

- intervention responsibility is identified be it provider, vendor, facility or service

- is participatory with the client and reflects client concurrence with initial plan and all updates thereafter

- multiagency or inter-professional collaboration is identified and coordinated

- care plan is documented in an approved format that can be of varying medium i.e., paper chart, EMR, ARIES etc.

- care plan is authenticated by both client and medical case manager by date and signature upon initial implementation and minimally every 6 months or upon each update (change) thereafter

- periodic reassessment is expected to detect changes in health status of the client but in no case shall reassessment extend beyond a 6 month period within the measurement year

- regardless of periodic reassessment the required measurement year 6 month interval reassessment will be comprehensive encompassing all parameters required during the initial medical case management assessment and will be documented as such

- **care plan must be updated, at a minimum, every six months during the measurement year**, unless the client initiated services within six months prior to the end of the measurement year (example: The Sacramento TGA fiscal year is March through February. If a client entered services in December, only the initial care plan would be feasible during the measurement year of March – February)

- Case conferencing required components

    - formal case conferences must be held at least once per quarter for all clients to coordinate care among providers from different services, fields, and disciplines

    - case conferencing should be done through a formal meeting with a multidisciplinary team that is appropriate to the needs of the client.

    - for clients experiencing significant changes or unexpected absence from care,

more frequent case conferences may be necessary

- during case conferencing, a review of the care plan and an evaluation of the services the client is receiving should be performed, as well as discussion of the client's current status (coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.)

- the client and/or their legal representative must be given the opportunity to provide input to the Medical Case Manager about their care plan for discussion at the case conference

- appropriate documentation must also be kept in the client chart or record including: names and titles of those attending the case conference, key information discussed, and whether the client or legal representative had input into the conference and the outcomes

- Treatment adherence counseling requirements

  - monitor client treatment employing client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc.

  - determine who has the primary responsibility for giving medication, and shall provide HIV and adherence education to family members or caregivers as applicable

  - refer clients to additional treatment adherence services as needed

  - assess for barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)

  - communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed

  - monitor laboratory values as appropriate

The medical case manager shall document all medical visits including any CD4 count and/or viral load tests during the measurement year.

QUALITY ASSURANCE AND SUPERVISION

All agencies providing Medical Case Management must have a quality assurance plan in place describing a supervisory review to critique documentation of client needs and if those needs were addressed.

Required Standards:

- a representative sample of at least 10 percent of charts of active Medical Case Management clients must have a supervisor review annually
- all clients who are discharged from Medical Case Management must also have a supervisor review within 3 months of that discharge
- reviews must be documented in the client chart with supervisor signature, date of review, and associated findings
- the review process must be conducted by a licensed provider
- in lieu of an internal licensed provider the agency must have in place a process in which an external licensed provider is utilized for the required review
- Provider reviewers may not perform a review of their own clients' chart(s).

DOCUMENTATION STANDARDS

Client Record:

- all Medical Case Management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record within 48 hours and entered into ARIES within two (2) weeks as appropriate.
- all documentation of activities must be legible, signed, and dated by the Medical Case Manager or authenticated in the an electronic manner consistent with an electronic health record or other record system

Memoranda of Understanding (MOUs), Releases of Information, or other standardized agreements may be necessary to ensure participation in the multidisciplinary team by all necessary staff.

Monitor Treatment Adherence: Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client. As needed, the Medical Case Manager

TRANSFER AND DISCHARGE

The agency shall maintain a systematic process addressing transfer of the client to another program or medical case manager.

Conditions for appropriate transfer, discharge or case closure include:

- client achieves self sufficiency
- loss of financial eligibility
- client and/or client's legal guardian requests that the case be closed
- client is found not to be HIV+
- client relocates outside of service area
- client lost to follow-up defined as a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative
- client refuses to participate in care planning, engagement in required responsibilities or exercise of reasonable self-care management
- falsification of required information/documentation
- client behavior patterns that are threatening, abusive or disrupting to the effective, safe and reasonable provision of service or create eminent potential harm to agency personnel

Standards for client transfer, discharge or closure include:

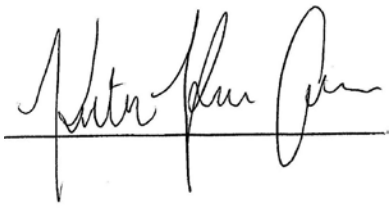
- matters related to transfer, discharge or closure are discussed through in-person interaction with the client or client's representative
- circumstances necessitating service termination outside of routine transfer, discharge or closure require consultation and concurrence with appropriate agency management
- involuntary termination of service requires implementation of an established agency protocol that minimally includes the following components
    - client notification process and complete with timelines
    - notice of appeals process
    - exploration of alternative care that is coordinated with the receiving service
    - process for intermittent suspension of service

- documentation of the reason for transfer, discharge, or closure describes discussion with the client and options for other service provision when applicable (preferably face-to-face) and includes a service transition plan

GRIEVANCE PROCESS

Client conflict or care management disagreement resulting in medical case management services termination will be addressed through the agency's specific grievance procedure.

If a resolution is not mutually resolved between the client and agency, then the case will be reviewed by the Fiscal/Administrative Agent (FAA) and a written response sent to all parties involved (e.g. agency, client) within twenty (20) working days with a disposition. If an extension is needed, a letter shall notify all parties involved of an extension for an additional ten (10) working days. Final disposition shall occur no later than thirty (30) working days following the initial filing with FAA.

Adopted:  Date: 12/31/19

Kristina Kendricks-Clark, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Respite Service Standards

No.: SSC 02
Date Approved: 07/22/98
Date Revised: 06/27/18
Date Reviewed: 06/27/18

As directed by the HIV Health Services Planning Council through established priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. Any respite services that are provided by agencies and paid for through Ryan White funding will be part of a comprehensive medical care plan that promotes the optimal state of health for the afflicted individual and shall be related to healthcare or other critical needs.

2. Ryan White funding is to be expended in a cost effective, equitable manner based upon client need verification. Clients may present to respite services through self-referral or agency referral. Payment for respite services through Ryan White funding are authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

3. In accordance with the above:
Respite care is an intermittent, temporary service provided by respite workers for individuals providing primary care to a person with HIV Disease. Respite services are time limited and episodic. In home and out of home respite care are designed to relieve parents, guardians or caregivers from the continuous responsibility of caring for a person with HIV Disease. These services are not intended to substitute for day care or child care while a caregiver is working or attending school or for routine care where a regular caregiver could be used. Respite services shall be provided in a culturally and/or linguistically competent manner which is respectful to the client's cultural health beliefs, practices and preferred language.

While the purpose of respite is to provide temporary relief from the continuous responsibility of caring for or an HIV infected individual, it is important to note that respite services are time limited and therefore are not available on an on-going basis. Those clients in need of home health services on an on-going basis should be referred to an appropriate home health provider.

A. Criteria
Those consumers who have special care needs due to severe medical problems directly related to HIV disease or a high-risk condition which requires the special attention of a trained respite worker may qualify for respite services.

The presence of HIV disease in and of itself does not constitute eligibility for respite services. There must also be the presence of a care need that exceeds the normal care for a child or adult of the same age.

Respite services will be provided by a respite agency, home health agency or private vendor individual. Private vendor individuals will be paid minimum wage and agency personnel will be paid the employer contracted negotiated rates.

Respite Care providers are expected to comply with the Universal Standards of Care, as well as the stipulated standards below:

B. Qualifications

I. Vendor workers will demonstrate the skills, experience, and qualifications appropriate to providing respite care services. When the client designates a community respite care giver who is a member of his or her natural network, this designation suffices as the qualification.

II. If a respite caregiver is from the client's network, the client signs a disclaimer acknowledging that the caregiver may not always meet all of the requirements expected of the agency's paid staff, and that the agency is not responsible for any issues that may arise as a result of this arrangement.

C. Amount of Service

The base amount of hours of service will be determined by the HIV Health Services Planning Council on an annual basis, unless there are extenuating circumstances within the household.

The client and/or the Agency will do an initial assessment to establish the level of care necessary. The assessment activity is not considered part of the client's base hours.

4. RW Agencies which provide Respite Services shall develop and adhere to budgets for Respite Services which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on RW funded Respite Services. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

5. Providers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

6. RW Agencies shall provide a means by which providers can obtain in-service training and advice related to interpreting client medical needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake.

Signed: _____ Date: 06/27/18

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Dental Services

No.: SSC03
Date Approved: 6/98
Date Revised: 06/27/18
Date Reviewed: 06/27/18

As directed by the HIV Health Services Planning Council established priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. As such, any Dental services which are provided by agencies and paid for using Ryan White Part A and Part B funding shall be related to healthcare or other critical needs that present barriers to healthcare access or maintenance.

2. Ryan White CARE Act Part A and B funding is to be expended in a cost effective, equitable manner which is based upon verified client need and encourages self-reliance of clients. Clients may be referred to Dental Services through case management services, their medical provider, or self- referral. Regardless of referral source, Dental Services which are paid for with Ryan White Part A and Part B funds shall be delivered only after verification of client eligibility and payor of last resort. Dental services which are paid for with Ryan White Part A and Part B funds shall be provided in accordance with the allocation priorities and directives which are adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council").

3. In accordance the U.S. Department of Health Resources and Services Administration, HIV Performance Measures and with the above:

   A. Ryan White-funded Dental services must conform to the adopted Ryan White Dental Program Operations Manual and Dental Rate Schedule, as published by the Sacramento County Department of Health and Human Services.

   B. Providers shall provide oral health care to persons living with HIV, ensuring equal access across populations through direct service or referral processes that emphasize a full continuum of oral health care services including.

I. Service that is determined medically necessary, including diagnostic screenings, shall be paid for with Ryan White funds, as defined by the Ryan White Program Dental Program Operations Manual and Dental Rate Schedule.
II. An established referral system for urgent care matters and/or services needed by clients but not fundable through Ryan White.
III. A documented dental treatment plan
IV. Documentation of oral health education
V. Documented provision of one periodontal examination during the measurement year (March-February)
VI. Documentation of initial and updated health history including:
    a. Current medications
    b. Appropriate lab values
    c. Name of primary medical care provider
    d. Review of substance use (smoking/tobacco, alcohol and drug use)
VII. Documentation of progress, review and outcome of the dental treatment plan

C. Reasonable efforts will be made to overcome any barriers to access and utilization, including efforts to accommodate linguistic and cultural barriers.

D. All services will be provided in accordance with Public Health Service and American Dental Association Guidelines for treatment of HIV disease.

E. Dental Service providers shall ensure and provide documentation that the dentists, hygienists, oral surgeons, nurses, and others providing oral health care are appropriately licensed/certified to practice within their area of practice, consistent with California laws.

F. Provider staff must receive ongoing training/continuing education relevant to dental health assessment and treatment of persons living with HIV.

4. All Dental services shall be provided in a culturally and/or linguistically competent manner which is respectful to the client's cultural health beliefs, practices and preferred language.

5. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

6. Providers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical/dental needs of a client or on unique barriers to accessing medical/dental care which may be experienced by a client.

7. RW Agencies shall provide a means by which providers can obtain in-servicing and on-call advice related to interpreting client medical/dental needs.

8. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake.

Signed: 06/27/18

Susan Farrington, Chair Date

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Support Services

No: SSC 04
Date Approved: 12/98
Date Revised: 4/25/18
Date Reviewed: 4/25/18

As directed by the HIV Health Services Planning Council established priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

Policy: The Support Services standards which follow will be applied uniformly by any contract agency which receives Ryan White funding for the various support services listed in the provision of services to HIV+ persons seeking assistance. These standards are to be coordinated with other service standards, such as the dental or respite care standards, as needed. The standards are to be implemented in the context of the approved Case Management Model.

The support service categories are:

- Case management (non-medical)
- Child care services
- Pediatric developmental assessment and early intervention
- Emergency financial assistance (Other Critical Need)
- Food bank/home-delivered meals
- Health Education/Risk Reduction services
- Housing
- Legal Services
- Linguistics services (interpretation and translation)
- Medical Transportation
- Outreach services
- Permanency Planning
- Psychosocial support services
- Referral for health care/supportive services
- Rehabilitation services
- Respite care
- Substance abuse services – residential
- (Now part of MCM)

Procedure:

1. The following general guidelines will be applied to ALL areas of Support Services:
   a "The Ryan White legislation stipulates that 'funds received…will not be utilized to make payments for any item or service… which can reasonably be expected to be made …by sources other than Ryan White funds…this means that grantees and/or their subcontractors are expected to make reasonable efforts to secure other funding instead of Ryan White funds."

   b "Ryan White funds are intended to support only HIV related needs of eligible individuals. Grantees, planning councils, and consortia should be able to make an explicit connection between any service supported with Ryan White funds and the intended recipient's HIV status, or care-giving relationship to a person with HIV/AIDS."

   c All requests for services will be accompanies by an assessment of the individual's need for the designated services, completed by a designated representative of the case management agency. The completed assessment must contain an annual budget completed with the client.

   d Ryan White funds may <u>not</u> be given in the form of direct cash to clients.

   e Ryan White funds may <u>not</u> be used to fund the following:
   - Pet foods or maintenance products/care
   - Local or state personal property taxes
   - Employment, vocational rehabilitation or employment readiness services
   - Clothing
   - Social outings

   f All services shall be provided in a culturally and/or linguistically competent manner which is respectful to the client's cultural health beliefs, practices and preferred language.

2. Exceptions and Emergencies may be handled as follows:
   a The TGA's Fiscal Agent may grant exception to these guidelines in response to specific unusual or compelling situations or in case of emergency on a case-by-case basis.

   b Emergencies may be defined around the following specific support service categories only: housing, food, transportation and medication assistance. Other one-time needs are defined as exceptions.
   c Exceptions and emergencies must be documented in the case record and signed by an agency's authorizing person.

   d All exceptions must be time limited.

3. Specific Support Service standards, by category, are to be applied as followed:

   a Food Vouchers, Food Banks, Meals, Nutritional Supplements, Vitamins
      1 Definition: Assistance with food is to be provided according to local needs, in the form of food banks, home-delivered meals or vouchers. The overall intention is to help meet basic needs and to maintain health.

      2 Instructions: Case managers will facilitate last resort determination for food assistance through identifying available resources for food in the community, as well as by providing documented referrals to these other resources.
         a Case Managers will then complete a budget with any client requesting food assistance, documenting a plan for maintaining their access to food/food resources.

         b Agencies providing food assistance in the form of food vouchers or boxes will make every effort to purchase quantities that provide for discounts.

   b Housing
      1 Definitions:
      Housing assistance is provided to enable individuals to remain in a stable environment, and/or gain or maintain access to medical care.

      Short term or emergency housing defined as necessary to gain or maintain access to medical care and must be related to either:

         a Housing services that include some type of medical or supportive services: including, but not limited to, residential substance abuse or mental health services (not including facilities classified as a Institute of Mental Diseases under Medicaid), residential foster care, and assisted living residential services; or
         b Housing services that do not provide direct medical or supportive services but are essential for an individual or family to gain or maintain access and compliance with HIV-related medical care and treatment. Necessity of housing service for purposes of medical care must be certified or documented.

      Short term or emergency assistance is understood as transitional in nature and for purposes of moving or maintaining an individual or family in a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate and/or ensure the individual or family is moved to, or capable of maintaining, a long term stable living situation.

      Emergency housing may include motels, hotels, rooming houses, etc.

2 Instructions:

a Rent subsidies will be based on client's actual rent or Fair Market resources identified and ratified by the HIV Health Services Planning Council and current directives for this service category.

b Rental agreement statement is required.

c Third-party notification to the agency from the rental holder is required, except in cases where the client demonstrates reliability in early notification to the Case Manager regarding payment difficulties, or in instances when such notification would result in client eviction.

d Clients must deplete other housing resources dollars, if available (e.g., HOPWA).

e At no time will payments exceed annual service directives caps as established by the HIV Health Services Planning Council.

f A one-time annual payment of move-in cost, not to exceed two month's rent at fair market rate, may be paid. In this instance, the client must have documentation of ongoing ability to maintain rental payments (e.g., check stub, disability income verification, etc.).

g No deposits shall be paid.

h Hotel/Motel payments may be utilized on an emergency or transitional basis . The HIV Health Services Planning Council's annual directives for this service standard may include a limitation on numbers of nights per year. This assistance will be accompanied by a documented plan to obtain more permanent housing.

c Insurance

1 Definition: Health Insurance continuation shall be provided to support continued access to quality HIV medical care.

2 Instructions:

a Health Insurance continuation "…may be used to pay for public or private health insurance co-payments and deductible for low-income individuals only."

b Health Insurance continuation payments shall be provided when continuation is a less expensive alternative than providing medical care through Ryan White funded services..

c Any assistance will assume the client and Case Manager have exhausted other options, and are actively engaging in efforts to enroll the client in alternative programs (e.g., OA-HIPP).

d Medical Transportation

1 Definition: Medical transportation assistance is provided to enable HIV+ individuals access to medical or social service appointments and/or resources which address basic needs.

2 Instructions:

a Agency representative shall make every effort to verify the client has no other resource to obtain medical transportation support (e.g., General Assistance bus pass).

b No-cost, non-profit or volunteer transportation services should be used as often as possible. Agency representatives must identify such resources with clients prior to provision of other options.

c Taxi services may be used, but should be considered last resort.

d "Funds…may <u>not</u> be used for direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance or license and registration fees."

e "Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported…" This reimbursement is available to the medical transportation provider (such as a friend or family member who drives the client) only.

e. Utilities

1 Definition: Utility assistance is available to enable individuals to remain in a stable, healthy living situation and to aid in the prevention of homelessness.

2 Instructions:

a Utility payment subsidies (for electric, propane, kerosene, gasoline, and natural gas) may have dollar limitations based on HIV Health services Planning Council's annual service directives.

b Any utility assistance provided will result in the Case Manager becoming a 3rd party notification for that utility service for one year.

c Emergency telephone assistance shall be available. In such an instance, the Case Manager will educate and assist the client in obtaining Universal Lifeline Service, if the client is not already enrolled. Service providers

throughout the TGA are expected to accept long-distance collect calls from clients as needed.

d Cell phones, pagers, Internet or other basic telephone services may be subsidized if they are the client's only basic telephone service

f. Other Support Services

1 Definition: This assistance is intended to provide access to a range of service which addresses needs frequently encountered by HIV+ individuals. The emphasis is on maintenance of health.

2 Instructions:

a Vendor payment is required.

b Examples of what may be compensated are as follows:

- Translation/Interpreter services for HIV+ individuals and their caregivers
- Glasses/Optician services (emergency only). Be sure to check for Medi-Cal authorization and/or Lyon's Club glasses availability
- Diapers or diaper rash ointment.
- Medicated shampoos
- Ointments
- Disinfectant soaps
- Pharmaceutical items (e.g., arm brace, durable medical equipment, syringes, etc.)
- Other urgent needs, as determined between client and agency representative

Signed: _____ Date: 4/25/18

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Eligibility & Fees for Ryan White Part A and Part B Services **No.:** SSC 05

Date Effective: 07/23/03
Date Revised: 06/27/18
Date Reviewed: 06/27/18

As directed by the HIV Health Services Planning Council established priorities, when funded, the following service standards will apply to Ryan White (RW) contracted service providers.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. Client access to Ryan White support services shall be determined in the context of each client's HIV/AIDS healthcare or other critical support need.

2. Ryan White CARE Act funding is to be expended in accordance with the Ryan White Treatment and Modernization Act, and in a cost effective, equitable manner which is based upon verified client need and encourages self-empowerment of clients. RW CARE Act Funding is to be the payer of last resort. Client eligibility for services which are paid for with RW CARE Act Funding shall be evaluated through medical or non-medical social service case management services provided in accordance with the allocation priorities and directives which are adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by an agency receiving Ryan White Part A and B funding ("RW Agency").

3. In accordance with the above:

A. All persons who test positive for HIV, and who reside in any of the counties which comprise the Sacramento Transitional Grant Area ("Sacramento TGA") or Yolo County or are homeless and claiming residency within the Sacramento TGA or Yolo County, shall be eligible for RW Funded services ("Eligible Persons"). Family members or caretakers who can document their relationship to persons living with HIV/AIDS may be classified as "Eligible Persons" for the purpose of receiving limited RW funded services. The financial eligibility criteria defined within this Standard apply equally to all Eligible Persons.

B. Eligible Persons will have a case file maintained by a Ryan White service provider. In order to document eligibility for Ryan White services, individual case files must contain mandatory eligibility documentation including:
   - Medical verification of HIV status;
   - Copy of photo identification if available.
   - Photocopy of Social Security Card or other qualifying card such as a State Benefits Card which includes a client's Social Security Number;

- Income verification i.e., pay stub, IRS tax return, governmental aid program documentation, SSI/SSDI Disability Award Letter, or personal statement of poverty;
- Third party health insurance coverage verification;
- Proof of residence or homelessness status (based on any combination of documentation and/or personal statements which are considered reasonable by each RW Agency).

  In circumstances where case management is provided in the "field" and it is not possible to obtain copies of the above documents, the case manager may date and sign a certification attesting to the presence of verification. Clients who do not possess a completed data set may receive services on an interim basis so long as the necessary documentation is obtained within 60 days of intake.

C. In accordance with current National Monitoring Standards for Ryan White HIV/AIDS Part A and Part B Grantees, as published in the National Register, determination of client eligibility **must be** documented every six months.

D. In accordance with the Ryan White legislation and the limitations set forth below, all Eligible Persons shall be subject to Service Fees, as assessed by each RW Agency at the time of service.

E. Fees charged to Eligible Persons will be based on the relationship of that person's household gross annual income to the Federal Poverty Level (FPL) as published annually by the US Department of Health & Human Services.

1. Persons earning an amount equal to or less than 100% of Poverty shall not incur Fees for RW Funded services.

2. Fee assessment to clients with incomes greater than 100% of poverty shall be subject to a discounted fee schedule, as noted below:

   i. 5% annual cap for patients with incomes between 100% and 200% of the FPL
   ii. 7% annual cap for patients with incomes between 200% and 300% of the FPL
   iii. 10% annual cap for patients with incomes greater than 300% of FPL

3. In the event that any client provides financial documentation that total out-of-pocket expenditures for health services in the current calendar year (1 January through 31 December) exceeds 10% of the anticipated gross income for the calendar year, such client shall be waived from any additional fees by any RW Agency from that date forward through the end of the current calendar year.

The Federal Poverty Guidelines can be found in the United States Federal Register at https://www.federalregister.gov and typing "Poverty Guidelines" in the search field.

F. Each RW Agency is responsible for implementing a discounted fee schedule as defined above. Fee collection procedures as determined reasonable and necessary by the services agency will be established, with any revenue collected considered "program income" which will be retained by said agency for the purpose of reinvestment into HIV/AIDS service delivery.

G. RW services which are primarily designed to enhance access by Eligible Persons to RW Services or to grievance procedures established by the various service agencies or the RW Fiscal Agent shall not be subject to any fee requirement. This exclusion specifically applies to Medical Case Management, Outreach, Non-Medical Case Management (Benefits and Enrollment Counseling), Health Education/Risk Reduction, Client Advocate or Ombudsman, and Peer Support Group services.

4. All Eligibility services shall be provided in a culturally and/or linguistically competent manner which is respectful to the client's cultural health beliefs, practices and preferred language.

5. Providers at Ryan White CARE Act funded Agencies may request Fiscal Agent interpretation, at any time, of these or any other Services Standards adopted by the HIV Health Services Planning Council.

6. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. Current and approved grievance policies and procedures for the RW Agency will be made available to each client upon intake. A copy of the signed grievance policy and procedure, including client acknowledgement, is to be included in the individual client file. Such policies and procedures shall include an explanation of the criteria and process for accessing any available advocacy or ombudsman services.

Adopted: Date: 06/27/18

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Substance Abuse Treatment Services

No.: SSC 06
Date Approved: 7/26/00
Date Revised: 4/27/16
Date Reviewed: 4/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Substance Abuse Treatment Services Standard will apply to all Ryan White contracted vendors that provide these services.

Reference: Ryan White HIV/AIDS Program Part A Manual:
http://hab.hrsa.gov/manageyourgrant/files/happartamanual2013.pdf

1. The provision of Substance Abuse Treatment Services shall be consistent with Service Standards policy 05 (SSC05) and consistent with the Substance Abuse Treatment Services program as outlined herein:

2. Clients presenting through self-referral will be accepted and authorized for substance abuse treatment services through Ryan White funding only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

   Substance Abuse treatment services which are not initiated through self-referral shall be administered or referred through Medical Case Management or medical provider coordination in accordance with the allocation priorities and directives adopted by the HIV Planning Council.

   Ryan White funds may not be expended or set-aside on a prospective basis for services not yet actually provided.

3. Consistent with Section 1 and 2 above, the following care and treatment guidelines apply:

   A. The HIV Health Services Planning Council makes no endorsement of any one substance abuse treatment strategy or program model. The following standards must be adhered to in any treatment intervention for Ryan White eligible clients:

      i. HIV related medical issues must always take precedent over substance abuse treatment program protocol.

ii. Any therapeutic treatment model must be tailored for those clients with extreme HIV related medical issues (as determined by a medical provider) not suitable for social model intervention.

B. Agencies receiving Ryan White CARE Act funding for substance abuse treatment services shall be licensed by the State Department of Alcohol and Drug Programs. Counseling services will be administered by a Certified Alcohol and Drug Abuse Counselor, an individual in the process of becoming a Certified Alcohol and Drug Abuse Counselor, or an individual with comparable experience and educational qualifications.

C. If the client is determined ineligible to participate in other federal, state or local substance abuse treatment programs, or if those services are unavailable, the following substance abuse treatment services will be made available to persons living with HIV (PLWH) within the Sacramento TGA provided funding is available, and consistent with: 1) the client's individual plan of care; 2) Planning Council Service Standards; 3) Health Resources and Services Administration guidelines; and, 4) Public Health Services (PHS) best practices:

i. **Community based counseling** including support groups.

ii. **Residential treatment services** (pending funding):

Ryan White funds may be used to extend client care up to an additional 90 continuous days beyond coverage authorized by other federal, state or local substance abuse treatment programs, if determined to be clinically necessary by the client's treatment team and authorized by the TGA's Fiscal Agent.

iii. **Detoxification services:** Ryan White funds may be used to cover cost for these services to provide client care up to 30 continuous days, if determined to be clinically necessary by the client's treatment team. Extensions beyond 30 days require approval of the TGA's Fiscal Agent.

Ryan White funds may be used to cover cost for these services to extend client care up to an additional six months beyond coverage authorized by other federal, state or local substance abuse treatment programs, if determined to be clinically necessary by the client's treatment team.

4. Providers of Substance Abuse Treatment services will continually improve the quality of care provided by engaging in activities outlined in USDHS PHS guidelines, such as a system of peer reviews, etc.

5. Substance Abuse Counselors at Ryan White (RW) Agencies may at any time submit to the Ryan White Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

6. RW Agencies shall provide a means by which Substance Abuse Counselors can obtain in-servicing and on-call advice related to client medical and other healthcare needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing any available advocacy or ombudsman services.

8. All Ryan White providers of substance abuse treatment services must have a quality assurance program and plan in place that is in compliance with the TGA Quality Management / Continuous Quality Improvement Plan and requirements set forth by the Continuous Quality Improvement Manager of the Fiscal Administrative Agent.

Adopted: Date: 4/27/16

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Service Directives

Policy Number: SSC 07
Date Approved: 9/27/00
Date Revised:

Subject: **General Policy Directives for Ryan White Funded Services**

Reference: Ryan White CARE Act (Amended 1996) SEC. IV-62
Action Taken by the Affected Communities Committee (8/28/00), as amended by the Executive Committee (9/13/00)

Policy: Over the past few years, the HIV Health Services Planning Council has taken great care to develop a coordinated system of care accessible to all PLWH/A within the Sacramento TGA. In order to continue this tradition, the Affected Communities Committee (ACC) has developed the following general policy directives for Ryan White-funded services:

ARCHIVE

1. Determination of Eligibility

Effective March 1, 2001, a determination of whether or not a client is eligible to Ryan White funded services will be made by no later than the end of the next business day.

2. Timely Provision of Services

Effective March 1, 2001, Ryan White funded services will be provided in a timely manner to all eligible clients when services are requested by the client or prescribed by the client's care provider, in accordance with the client's plan of care.

3. Share of Cost

Effective March 1, 2001, all providers contracted by the Ryan White CARE Act will implement the attached Financial Eligibility/Share of Cost for Ryan White Services Guidelines (SSC-05), as adopted by the HIV Health Services Planning Council.

4. Removal of Cap on Services

Effective March 1, 2001, the Planning Council will amend current and future Service Standard guidelines to remove maximum entitlements (or caps) for all Ryan White funded services for which there is no existing HRSA guideline, in accordance with the client's plan of care. In so doing, the Grantee will commit to periodic and sustained monitoring of provider agencies to ensure against provider and/or client abuse. Reports of said monitoring activities will be provided to the Council on a quarterly basis.

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Child Care Services

No.: SSC 08
Date Approved: 7/23/03
Date Revised: 4/27/16
Date Reviewed: 4/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Child Care Service Standard will apply to all Ryan White contracted vendors that provide child care services.

1. The provision of Child Care Services shall be consistent with Service Standards 05 (SSC05) and in accordance with the Child Care Services program as outlined herein:

2. Payment for child care services through Ryan White Care Act funding are authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

A. Child care services payment(s) will only be issued to the child care services vendor. Reimbursement shall not be issued to the client receiving child care service.

B. Reimbursement for child care services will be issued under the following stipulations:

   i. Client/parent or client/guardian must provide a receipt for service from a babysitter, family member, community member, or daycare agency.

   ii. The receipt must contain the name, business ID or social security number of the agency/person who provided child care.

   iii. Documentation of medical, social, or support service appointments must be on file, and must include the date and hours of service provided, including signature of the provider.

C. The client must release the TGA fiscal agent and service authorizing agency from all liability for the welfare of the child and/or the quality of the childcare provided, including the responsibility for the provision of child care. Documentation of this release shall be consistent with the internal procedure(s) of the authorizing agency and in accordance with any requirements stipulated by the TGA fiscal agent

D. In the event of extended hospital stay, Ryan White CARE Act funds will be used only until alternative child care arrangements can be made, but shall not exceed seven (7) days for a single occurrence, unless granted an exception by the Fiscal Agent.

3. If available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on Ryan White funded child care services for critical needs. Agencies shall assure that no client receives Ryan White CARE Act funded child care services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

4. Case Managers at Ryan White Agencies may, at any time, submit to the Ryan White Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

5. Ryan White Agencies shall provide a means by which Case Managers can obtain in-servicing and on-call advice related to interpreting client medical needs.

6. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the Ryan White Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file. Such policies and procedures shall include an explanation of the criteria and process for accessing the Planning Council's Client Advocacy Program.

Adopted: Date: 4/27/16

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Service Directives

Policy Number:	SSC 09
Date Approved:	3/28/01
Date Revised:	

Subject: **General Policy Directives Regarding Apportionment of Ryan White Funding**

Reference: Ryan White CARE Act (Amended 1996) SEC. IV-62
Action Taken by the Affected Communities Committee (9/25/00)

Policy: Over the past few years, the HIV Health Services Planning Council has taken great care to develop a coordinated system of care accessible to all PLWH within the Sacramento TGA. In order to continue this tradition, the Affected Communities Committee (ACC) has developed the following general policy directive for Ryan White-funded services.

This policy directive proposes to discourage the practice of apportioning funds at the provider level. The practice of arbitrary allocation by agency personnel is inconsistent with Council goals of increased access to services for PLWH in the Sacramento TGA, and minimization of service interruption to clients already in care.

INACTIVE

1. **<u>Appropriate Apportioning of Ryan White Funding</u>**
   Effective March 1, 2001, service providers contracted by the Sacramento TGA will agree to the distribution of Ryan White funds in accordance with the client's plan of care, and applicable service standards developed by the Council.

   The Grantee will commit to monitoring service providers and negotiating contracts to assure appropriate apportioning of CARE Act funds intended for use on an emergency basis.

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Utilities Assistance

No.: SSC 10
Date Approved: 7/23/03
Date Revised: 4/27/16
Date Reviewed: 4/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council the following Utilities Assistance Standard will apply to all Ryan White contracted vendors that provide utility assistance services.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. Utility Assistance that is provided by agencies and paid for through Ryan White funding will be part of a comprehensive medical care plan that promotes the optimal state of health. Utility assistance must meet the following criteria:

- preventing homelessness, or
- alleviating unhealthy living conditions for clients and their immediate families.

2. Ryan White funding is to be expended in a cost effective, equitable manner which is based upon client need verification. Payment for utility assistance services through Ryan White funding are authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

3. Established Standards:

A. In order to preserve a client's access to utilities service in the most cost effective manner, utilities assistance will be granted one (1) time for a client who receives a notice of late payment, or a shut off notice.

1. Continuation of assistance requires compliance to factors listed below: :
   - The client has enrolled in a reduced rate or financial assistance program offered by the utility provider (e.g., SMUD Energy Assistance Program Rate [EAPR] or PG&E's California Alternate Rates for Energy [CARE]);

   - The client has taken advantage of at least one utility conservation educational program designed for consumers (e.g., programs sponsored by Resources for Independent Living), provided such programs are available in the area where the client resides.

B. The term "utilities" shall be interpreted to include electric power, water and sewer service, natural gas and alternative heat sources such as propane, wood or fuel pellets for

homes which use such fuels as the primary source of heating. Purchase of containerized water may be included for homes lacking either a piped water connection or a well.

C. Any assistance for telephone utilities shall be limited to the monthly fee for Universal Lifeline Service for land-based phones. Ryan White funds shall not be used for pager services or for wireless phone service except in geographic areas where no cost-effective alternative exists.

D. Medical Case Managers shall ensure that all clients who request housing related assistance of any kind, including utilities assistance, are made aware of and encouraged to access the weatherization subsidy programs available through utilities service providers or government agencies.

4. RW Agencies which provide Medical Case Management services shall develop and adhere to budgets for utilities assistance which reflect the principles outlined above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of those clients who are most at risk of homelessness or unhealthy living conditions. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council and the client is adhering to a budget developed mutually by the program staff and client.

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

6. RW Agencies shall provide a means by which Medical Case Managers can obtain in-servicing and on-call advice related to interpreting client medical needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing the Planning Council's Client Advocacy Program.

Adopted: Date: 4/27/16

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Medical Transportation Services

No.: SSC 11
Date Effective: 7/23/03
Date Revised: 4/27/16
Date Reviewed: 4/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Utilities Assistance Standard will apply to all Ryan White contracted vendors that provide medical transportation services.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. As such, any medical transportation services which are provided by agencies which receive Ryan White CARE Act funding ("RW Agencies") shall be related to healthcare or other critical needs.

2. Ryan White CARE Act funding is to be expended in a cost effective, equitable manner which is based upon verified client need and encourages self-empowerment of clients. Medical Transportation services which are paid for with Ryan White CARE Act funds shall be administered through medical case management services which are provided in accordance with the allocation priorities and directives which are adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by a RW Agency.

3. Established Standards:

   A. Ryan White medical transportation funds must be prioritized by purpose:
      (1) medical appointments
      (2) alternative healthcare appointments
      (3) other critical needs as related to medical care needs, i.e., taking a client to an SSI appointment to maintain medical benefits

   B. Ryan White medical transportation funds must be prioritized by means of transport so as to preserve the most cost effective means:
      (1) family, friends and other sources of transport for which the RW Agency does not incur any direct cost.
      (2) public transit (to include Para-Transit)
      (3) volunteer services
      (4) taxi service

C. Taxi services shall only be authorized under the following criteria:
- The client is experiencing a health condition which is incompatible with public transit, AND
- other means of transportation is not immediately available for an unanticipated or changed appointment date with a provider of healthcare or supportive services, OR
- The client is experiencing a time-related, unavoidable emergency, OR
- The client requires an escort for transportation for medical necessity.

D. Agency Staff/Volunteer Licensure and Liability:
- **Licensure:** All agency staff, contractors, consultants, and volunteers who provide transportation, shall be properly licensed by the State of California.
- **Insurance:** All agency staff, contractors, consultants, and volunteers who provide transportation shall use registered and insured vehicles.
- **Liability:** Volunteers who transport clients are informed of their responsibilities and obligations in the event of an accident, including the extent of their liability.
- Signed and dated confirmation form on file with provider.

4. RW Agencies which provide Medical Case Management services shall develop and adhere to budgets for medical transportation services which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on RW funded transportation services for critical needs. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

6. RW Agencies shall provide a means by which Medical Case Managers can obtain in-servicing and on-call advice related to interpreting client medical needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing the Planning Council's Client Advocacy Program.

Adopted: _____ Date: 4/27/16

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Food and Nutrition Services

No.: SSC 12
Date Approved: 1/22/03
Date Revised: 4/27/16
Date Reviewed: 4/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Food and Nutrition Service Standard will apply to all Ryan White contracted vendors that provide Food and Nutrition services.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. Food and Nutrition services that are provided by agencies and paid for through Ryan White CARE Act funding is part of a comprehensive medical care plan that promotes an optimal state of health for the afflicted individual. Food and nutrition services must meet criteria as noted below: be:

- Medically appropriate
- Nutritionally sound as referenced by the Choose MyPlate Program United States Department of Agriculture guidelines
- Consistent with any restrictions otherwise noted by an individualized client medically prescribed diet

These expectations shall apply whether such services are provided directly by a Ryan White Agency (RW Agency), or by a non-RW Agency to which the client is referred by a RW Agency.

2. Ryan White funding is to be expended in a cost effective, equitable manner which is based upon verification of client need. Payment for Food and Nutrition services through Ryan White funding is authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

3. Established Standards:

A. Nutritional Counseling services shall be provided by a Registered Dietitian or other qualified professional working in consultation with HIV qualified physicians.

B. Food distributed by food banks and others shall be fresh (for packaged food, not beyond recommended expiration dates), free from filth or vermin and, until distributed to consumers, properly stored and handled to maximize shelf life and minimize spoilage. Referrals shall only be made to food providers which have valid, current permits issued by the appropriate county health department or otherwise meet accepted community standards. It is recommended and preferred that food packages contain items which can be used together to create nutritionally complete meals for a minimum of ***three days*** per person or family. Referrals by service providers to food

banks and other services which are not themselves recipients of Ryan White funding, shall be based in part on client feedback on their satisfaction with the quality of such services.

C. Expenditures for food shall be controlled to minimize opportunities for inappropriate use. Vouchers or debit cards shall be issued only to qualified clients and, if possible for reasonable cost. Vouchers or cards must be labeled or coded to prevent purchase of alcoholic beverages, tobacco products or games of chance. In order to prevent resale of vouchers or food cards, clients must, return a used or expired voucher or debit card to the issuing service provider in order to obtain a replacement. The following criteria must be met for voucher/card issuance:

   i. Eligible clients must provide proof of need with each request and such proof must be documented and added to the case file.

   ii. Upon receipt of a Ryan White food voucher or debit card, clients will be instructed that additional nutrition assistance will not be granted until completion of the following:

      1. Client is referred to and attends nutritional skills course (as available), and/or;

      2. Client produces a grocery receipt displaying that the Ryan White food voucher was used consistent with the established nutrition standards herein.

D. Providers of Food or Nutritional Services shall not use their professional status as a means to promoting products in which they may have a financial interest in.

4. Ryan White Agencies which provide Medical Case Management services shall develop and adhere to budgets for Food and Nutritional Services which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed equitably to achieve assistance to the greatest number of clients who are most at risk for nutrition related health problems. Agencies will assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical or other healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

6. Ryan White Agencies must provide a means by which Medical Case Managers can obtain in-servicing and on-call advice related to interpreting client medical and other healthcare needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent

review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing any available advocacy or ombudsman services.

Adopted: 4/27/16

Susan Farrington, Chair Date

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Complementary/Alternative Therapies
Service Standards

No.: SSC 13
Date Approved: 01/22/03
Date Revised: 4/27/11
Date Reviewed: 4/27/11

INACTIVE

As directed by the HIV health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psycho-social and support services which significantly improve access and adherence to such medical services. As such, any Alternate Therapies services which are provided with Ryan White funding ("RW Agencies") will be fully integrated with each client's medical care. For purposes of this Standard, the term Alternate Therapies shall include only services which are funded at any given time by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council") and are considered eligible services by the Health Resources Services Administration. As of the date of writing this Standard, the funded services included Chiropractic, Acupuncture and Therapeutic Massage.

2. Ryan White funding is to be expended in a cost effective, equitable manner which is based upon verified client need and encourages self-empowerment of clients. Alternate Therapies services which are paid for with Ryan White funds shall be administered or referred through Medical Case Management services which are provided in accordance with the allocation priorities and directives which are adopted by the HIV Planning Council: Ryan White funds shall not be expended or set-aside on a prospective basis for services not yet actually provided.

3. In accordance with the above:

   A. Alternate Therapies services must be prescribed by a qualified Medical Provider as part of an integrated HIV/AIDS Plan of Care. Each prescription for Alternate Therapies shall be recognized for a period not to exceed three months. Limitations on the quantity or frequency of services may be established from time to time by the Health Resources and Services Administration ("HRSA") or the HIV Planning Council. In the event that a prescription calls for quantities or frequencies of service which exceed such limitations, the limitations shall govern.

   B. It is anticipated that providers of Alternate Therapies and Medical Providers will proactively and regularly communicate and make available to each other relevant information pertaining to common clients.

C. Providers of Alternate Therapies services shall be licensed or certified as follows: Chiropractic, Doctor of Chiropractic; Acupuncture, Licensed Acupuncturist; Therapeutic Massage, Certified Massage Therapist.

D. Providers of Alternate Therapies services shall not use their professional status as a means of promoting products in which they may have a financial interest to either clients or Medical Providers.

4. If available funding levels are anticipated to be less than the total need for Alternate Therapies, agencies shall ensure that funds are distributed among the maximum possible number of clients who are most at risk for health problems related to the need for Alternate Therapies. In the event that two or more clients with similar healthcare needs have presented valid prescriptions for services and funding is not sufficient to serve all of those clients, the rule of first-come/first-served shall prevail. Agencies shall assure that no client receives any RW Funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

6. RW Agencies shall provide a means by which Medical Case Managers can obtain in-servicing and on-call advice related to client medical and other healthcare needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. Such policies and procedures shall include an explanation of the criteria and process for accessing any available advocacy or ombudsman services.

INACTIVE

Kane R. Ortega

Adopted: Date: 4/27/11

Kane Ortega, Chair

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Mental Health Services

No.: SSC 14
Date Approved: 12/13/06
Date Revised: 7/27/16
Date Reviewed: 7/27/16

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Mental Health Services Standard will apply to all Ryan White contracted vendors that provide mental health services.

Descriptions:

Ryan White-funded mental health services consist of group and individual counseling sessions for HIV infected or affected adults, children and families provided by psychiatrists, psychologists, licensed clinical social workers or other qualified individuals.

Policies:

1. Ryan White funding is allocated for HIV/AIDS medical, psycho-social and support services to ensure client access to and continuity of care. Mental health service includes but is not limited to grief/bereavement intervention for family/significant others. Complimentary mental health intervention other than grief/bereavement therapy provided through Ryan White funded agencies will be integrated into each client's medical plan of care. A comprehensive medical plan of care will be individualized to client needs consistent with intervention that promotes an optimal state of wellness.

2. Ryan White funding will be expended in a cost effective, equitable manner based upon verification of client need and processes.as outline below:

- Ryan White is the payor of last resort
- Substance abuse behavior alone will not be a basis for service denial
- Self-referral
- Medical case management referral ensuring facilitated assistance to the client
- Authorized behavioral health assessment up to three (3) one (1) hour sessions
- A treatment plan will be established with specific emphasis on client sustainability for continuity of medical care
- All behavioral health intervention plans will incorporate consideration of current HIV/AIDS drug regime including an itemized listing of all medications currently being taken by the client
- All behavioral health intervention plans will be reviewed by a licensed therapist at intervals appropriate for the stability of the client and in accordance to accepted regional standards of care

- Psychotropic medication management will be coordinated with the primary HIV/AIDS medical specialist to ensure compatibility with the current HIV/AIDS medical drug regime. This coordination must be documented in the behavior health plan of care
- With written permission (signed Ryan White Release of Information Authorization form) of a Mental Health client, a multidisciplinary (Pharmacy, Psychiatry, Psychology, Medical, Medical Case Management) review of the client's care plan will occur at least annually to determine necessity/efficacy of continued Mental Health treatment versus other available options.

A. Crisis intervention services will be provided based on the presentation of dangerous behaviors, regardless of the cause (e.g. HIV-based, dual diagnosis issues, etc.) or upon the referral by a health care provider for diagnostic clarification or immediate intervention deemed necessary to maintain the safety of the client or others.

B. Treatment to individuals presenting with dual-diagnosis will be individualized based on client characteristics and environment utilizing the most appropriate intervention model consistent with regional best practices.

C. Ryan White mental health services are preferably provided by professionals knowledgeable or having expertise in interdisciplinary case management of individuals and families affected by HIV/AIDS. Specialty consideration is required for the following:

   - Pediatric clinical specialist for infants, children and adolescents
   - Medical and psychiatric subspecialties based on clinical status of client
   - Pharmacology consultation for integrated psychotropic/medical drug regime

D. Ancillary services for PLWH families and significant others may be necessary to support the client in managing their health and improving continuity with medical and psychiatric intervention. Services for this purpose are limited to the following:

   - Coping and living with the disease education, general support for the afflicted individuals continuity of care that is time limited based on the dynamics of the care environment and focused goals of the overall medical treatment plan
   - Grief/bereavement services will be provided on a limited term basis as determined necessary by the primary case manager or until another resource is identified and engaged. Brief/bereavement services extending beyond a 90-day term requires pre-authorization from the Ryan White Fiscal Agent.

E. Group sessions may be offered as part of, or as an alternative to, individual treatment plans. Referrals shall be made available to clients seeking group services when slots are not available in the existing group.

F. All providers of mental health services will comply with the California Board of Behavioral Sciences treatment regulations.

4. RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

5. RW Agencies shall provide a means by which Mental Health providers can obtain in-servicing and on-call advice related to client mental health and other healthcare needs.

6. Coordination with other components of the Ryan White system of care is critical and required.

7. All Ryan White providers of mental health services must have an internal grievance process in place. Each client must receive a copy of the agency's grievance policy and a signed copy of the grievance policy must be maintained in the clients' file. Information about how to access this process must be posted conspicuously in public areas of the agency. It must include provisions for informing clients of its existence, and how to begin the process. Clients also have the right to file a grievance with appropriate state licensing agencies (i.e. Board of Behavioral Sciences).

8. All Ryan White providers of mental health services must have a quality assurance program and plan in place that is in compliance with the TGA's Quality Management / Continuous Quality Improvement Plan and requirements set forth by the Quality Management Manager of the Fiscal Administrative Agent.

Adopted: Date: 7/27/16

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Housing Assistance Services

No.: SSC 15
Date Approved: 5/26/04
Date Revised: 2/22/17
Date Reviewed: 2/22/17

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council the following Housing Assistance Standard will apply to all Ryan White contracted vendors that provide housing services.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical care including, psycho-social and support services designed to significantly improve client access and adherence to such resources. Housing Assistance services that are provided by agencies and paid for through Ryan White funding will be part of a comprehensive medical care plan that promotes the optimal state of health for the afflicted individual and shall be related to maintaining a client's housing stability, thereby improving ability to maintain or access medical care.

2. Ryan White CARE Act funding is to be expended in a cost effective, equitable manner based upon client need verification. Referral to housing services is accomplished through medical case management providers, or by self-referral. Payment for housing assistance services through Ryan White funding are authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

3. In accordance with the above:
   A. Definition:
      Ryan White CARE Act funded housing assistance is only to be used for short term or emergency housing. Short term or emergency assistance is understood as transitional in nature for the purpose of moving or maintaining an individual or family into a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate and/or ensure the individual or family is moved to, or capable of maintaining, a long term stable living situation.

   B. Instructions:
      Housing assistance may include rent subsidies, move-in costs other than deposits, or emergency shelter. All housing assistance will be provided through vendor paid dollars. Rental/shelter verification (rental agreement, receipt, etc.) is required.

      Clients must deplete other housing resources dollars, including HOPWA, before receiving rent subsidies through Ryan White. At no time will total housing assistance, whether provided solely through rent subsidies, move-in costs, or emergency housing, or

through a combination thereof, exceed the equivalent of two months' rent, unless specific contractual agreements with funding sources provide extensions.

i. Rent Subsidies
   a. Clients requiring rent subsidies will contribute as much of their monthly income to the cost of rent as is feasible. The actual percentage of the client's income to be used in this calculation shall be based upon what the client can reasonably dedicate to housing costs, as determined by the case management provider. The remaining balance between the client's contribution and their actual rent may be subsidized through Ryan White housing assistance.

   b. A Medical Case Manager will assess the housing situation of any client receiving a rent subsidy twice within a twelve month period. The assessment will be used to identify more affordable housing solutions, which might include relocating, or shared housing.

   c. Ryan White rent subsidies will not be provided to clients currently or simultaneously receiving any other federally subsidized housing assistance.

ii. Move-in Costs
   a. A one-time annual payment of move-in cost, not to exceed two month's rent may be paid.
   b. Client must have documentation of ongoing ability to maintain rental payments (e.g., check stub, disability income verification, etc.).
   c. No deposits shall be paid.

iii. Emergency Housing
   a. Emergency housing may include motels, hotels, rooming houses, etc.
   b. Emergency housing payments may be utilized on an emergency or transitional basis for no more than 14 nights per year, at the most reasonable rate available in the community for emergency per-diem housing which meets acceptability standards, unless specific contractual agreements with funding sources provide extensions.
   c. This assistance will be accompanied by a documented plan to obtain more permanent housing and such medical case management and advocacy as is needed to pursue the plan.

4. RW Agencies which provide Housing Assistance shall develop and adhere to budgets for housing services which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on RW CARE Act funded housing services for critical needs. Agencies shall assure that all clients receiving any RW CARE Act funded services are found to be eligible for services under such eligibility standards as may be adopted by the planning council.

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation and/or exceptions of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

6. RW Agencies shall provide a means by which Medical Case Managers can obtain in-service training and advice related to interpreting client medical needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake.

Adopted: _____ Date: 2/23/17

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Other Critical Needs

No.: SSC 16
Date Approved: 5/26/04
Date Revised: 2/22/17
Date Reviewed: 2/22/17

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council the following Other Critical Needs Standard will apply to all Ryan White (RW) contracted vendors that provide Other Critical Needs services.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical services and for psycho-social and support services which improves access and adherence to medical care. All such Other Critical Needs services initiated by agencies receiving Ryan White funding will be related to sustaining continuity of healthcare as defined by HRSA.

2. Ryan White CARE Act funding is to be expended in a cost effective, equitable manner that is based upon verified client need. Facilitating self-empowerment of the client's coordination of Other Critical Needs services shall be carried out through case management in accordance with the allocations, priorities and directives adopted by the Sacramento TGA HIV Health Services Planning Council (Planning Council), or through an alternative assessment process administered by a RW agency.

3. To be eligible for Other Critical Needs assistance, the requested service must directly assist the client in overcoming a barrier to accessing medical care or adhering to a medical regimen.

4. Agencies shall ensure that RW CARE Act funded services are provided only to such clients that meet eligible criteria as defined or stipulated within the Eligibility Standards as adopted by the Planning Council.

5. Standards applied include:

    a. Assistance that is intended to provide access to a range of services which address needs frequently encountered by People Living with HIV (PLWH) with emphasis on self-care health maintenance.

    b. All requests for funding will be accompanied by an assessment of the individual's need for the designated service, completed by a representative of the case management agency.

c. Assessment findings must be documented in case notes.

d. Services must be vendor based. Direct cash payments to clients are prohibited.

e. Case managers will work with clientele to develop a budget that enables the individual to live within their existing resources.

6. RW Agencies which provide Other Critical Needs assistance shall develop and adhere to budgets that comply with the principles and standards described herein. When funding levels are anticipated to be less than the total need, agencies shall ensure that distribution of remaining funds will maximize number of clients who rely on RW CARE Act funded Other Critical Needs assistance.

7. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation and/or exception of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

8. RW Agencies shall provide a means by which Medical Case Managers can obtain in-service training and advice related to interpreting client medical needs.

9. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake.

Adopted: _____ Date: 2/23/17

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: HIV Psycho-Social Support Group Service Standard

No.: SSC 17
Date Approved: 12/01/04
Date Revised: 04/26/17
Date Reviewed: 04/26/17
Inactive: 03/01/07

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following HIV Psycho-Social Support Group Service Standard will apply to all Ryan White contracted service providers that conduct psycho-social support group services.

1. Ryan White funding is to be used for HIV/AIDS medical care including, psycho-social and support services designed to significantly improve client access and adherence to such resources. Any HIV Psycho-Social Support Group services that are provided by agencies and paid for through Ryan White funding will be part of a comprehensive medical care plan that promotes the optimal state of health for the afflicted individual and shall be related to healthcare or other critical needs.

2. Ryan White funding is to be expended in a cost effective, equitable manner based upon client need verification. Therefore, clients may present to Psycho-Social Support Groups through self-referral or agency referral. Admittance to Psycho-Social Support Groups is at the discretion of the support group facilitator and shall be based upon the facilitator's assessment of the presenting client and the clients' compatibility with the existing group. Payment for HIV Psycho-Social Support Group services through Ryan White funding are authorized only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

3. In accordance with the above:
   A. Psycho-Social Support Group services shall be led by an individual with documented experience and/or training in group dynamics and group facilitation. The leader must have knowledge and experience with HIV issues.
   B. Clients needing Psycho-Social Support Group services should be placed in the support group most compatible with their life situations and/or experiences living with HIV.
   C. Ground rules and the groups' purpose shall be established and periodically evaluated for all support groups funded by Ryan White funds. The ground rules will be used to minimize interruption in productive group discussion. Ground rules will be reiterated prior to beginning each session.

D. With the exception of the facilitator and guest presenters, participation in support groups shall be limited to individuals living with HIV (PLWH), as non-PLWH may intrude on trust and open discussion. Providers conducting Psycho-Social Support Group services should have the ability to work with families of PLWH in a separate setting.
E. Psycho-Social Support Groups will be maintained at the size most conducive to productive sharing, listening, and discussion by all members.

4. Ryan White (RW) contracted service providers that conduct HIV Psycho-Social Support Group Services shall develop and adhere to budgets for HIV support groups which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on RW funded HIV support group services for critical needs. Providers shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the planning council.

5. Medical Case Managers at RW contracted service providers may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

6. RW contracted service providers shall provide a means by which Medical Case Managers can obtain in-service training and advice related to interpreting client medical needs.

7. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW contracted service provider shall be made available to each client upon intake.

Adopted: Susan Farrington Dated: 4/26/17

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Medical Nutritional Therapy Service Standards for Persons Living with HIV/AIDS

No.: SSC 18
Date Approved: 09/22/10
Last Revised: 04/26/17
Date Reviewed: 04/26/17

Policy: The attached document represents the service standards to be utilized when providing medical nutritional therapy to Ryan White eligible clients in the Sacramento TGA. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

As directed by the HIV Health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

PURPOSE OF MEDICAL NUTRITIONAL THERAPY

The Health Resources Services Administration (HRSA) defines medical nutritional therapy as being provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician.

Nutritional services not provided by a licensed, registered dietician shall be considered a support service. Food, nutritional services and supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietician also shall be considered a support service.

Key activities include:

- initial comprehensive nutritional assessment of client's needs and personal support systems,
- development of a comprehensive, individualized Care Plan within the first 60 days of client's initial appointment;
- coordination of the services required to implement the Care Plan;
- client monitoring to assess the efficacy of the Care Plan; and
- re-evaluation and revision of the Care Plan as needed.

The Sacramento Transitional Grant Area (TGA) views access to adequate and appropriate food as fundamental, and is the foundation of any medical therapy program which has numerous benefits. For people living with HIV/AIDS, a well-balanced diet can help strengthen the immune system, prevent infections and reduce hospitalizations. Medical nutritional therapy is an on-going process to empower clients by encouraging their ability to function independently.

VALUES OF LICENSED NUTRITIONAL THERAPY:

The Licensed Nutritional Therapy system will be:

- Client focused – The client and the Nutritionist will reach a consensus as to the client's nutritional needs, and as to the prioritization of those needs, which will culminate in the creation of an individualized nutrition plan of care.
- Focused on maintaining clients in, or assisting clients to develop constructive lifestyles and life choices that will allow clients to maintain routine medical care. Licensed Nutritional Therapists will work with clients to proactively address and resolve issues that consistently and negatively impact the client's nutritional health.
- Committed to empowering the client – Licensed Nutritional Therapy is an ongoing process to empower clients by encouraging their ability to function independently in maintaining good nutritional health.
- Goal-oriented – Specific mutually agreed upon nutritional goals will be set in client care plans in order to assess progress and effectiveness of medical Licensed Nutritional Therapy.
- A flexible model – Licensed Nutritional Therapists will periodically reevaluate and be responsive to client's immediate, emerging, or otherwise changing nutritional needs.
- Culturally proficient – Licensed Nutritional Therapists must be able to address clients in terms and contexts that are understandable and account for the client's personal situation/environment.
- Efficient – The system will assess different stages of need and provide different services based upon need.
- Cost-effective – Licensed Nutritional Therapy will identify and encourage the use of resources that will effectively prevent the client from having to access more expensive alternatives.
- Accessible – Licensed Nutritional Therapy will be delivered appropriately to all clients, regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.
- Collaborative – Licensed Nutritional Therapists will facilitate referrals to provider services and other supportive resources that most closely match client nutritional needs.

GOALS OF MEDICAL NUTRITIONAL THERAPY

The goal of medical nutritional therapy for PLWH/A is to:

- Optimize nutrition status and immunity;
- Prevent the development of nutrient deficiencies;
- Promote the attainment and maintenance of optimal body weight and composition;
- Maximize the effectiveness of antiretroviral agents;
- In coordination with the client, create a care plan that addresses the nutritional needs of the

individual client;
- Promote communication and collaboration between the clients and all persons involved in the client's care;
- Educate the client on available resources and assist them in accessing those resources.

MEDICAL NUTRITIONAL THERAPY EDUCATION REQUIREMENTS & TRAINING

All programs providing medical nutrition therapy services will operate under the direct supervision of a registered dietitian or nutritionist consistent with California Business and Professions Code section 2585-2586.8. Registered dietitians providing medical nutrition therapy will possess advanced knowledge of nutrition issues for people living with HIV, and maintain professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as administered by the Commission on Dietetic Registration.

1. The minimum education and/or experience requirements for Registered Dietitians is:
    a. A Bachelor's degree in nutrition and related sciences;
    b. A supervised dietetic internship or equivalent
    c. A national exam which credentials her/him as a Registered Dietitian by the Commission on Dietetic Registration
    d. Continuing education is required to maintain a registered dietitian certification.
2. Dietetic Technician Registered (DTR): A DTR is a food or nutrition expert who has completed the following:
    a. An associate's degree in nutrition and related sciences;
    b. National credential as DTR by completing a national examination;
    c. continuing education in food and nutrition;
    d. All DTRs must work under the supervision of an experienced Registered Dietitian.

MEDICAL NUTRITIONAL THERAPY PROCESSES

The core activities of medical nutritional therapy are:

- Assessment
- Nutritional Care Plan Development
- Nutritional Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Reassessment
- Transfer and Discharge
- Evaluation of Client Satisfaction

ASSESSMENT

Each client of medical nutritional therapy services will participate in at least one (1) initial face-to-face interview with a Registered Dietitian or DTR to assess their nutritional needs. The assessment will be used to collect, analyze, and prioritize information which identifies client needs, resources, and strengths for purposes of developing a Care Plan. Assessment will be conducted in accordance with written policies and procedures established by the individual Ryan White provider utilizing

appropriate Ryan White Program forms (including the Client Intake Form), as required.

At minimum, the following activities will take place during initial intake:

1. The Ryan White Program Intake form will be completed in its entirety.
2. The client will be assessed by a Registered Dietitian utilizing an appropriate evaluation instrument within 60 days. The client's Care Plan will be reassessed as needed.
3. The client's Informed Consent to Participate in the medical nutritional therapy program shall be obtained, signed by both the Registered Dietitian and the client, with a copy maintained in the client's record.
4. The client will be informed of their right to confidentiality and information privacy procedures.
5. The client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities. Additionally, the Release of Information Form must be updated annually.
6. The client will be informed of, and agree to the Client's Rights and Responsibilities form.
7. The client will be informed of the agency's Grievance Procedure.
8. The client will be informed of the role and purpose of medical nutritional therapy.
9. Create a client file and archive all relevant documents and forms.

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services.

CARE PLAN DEVELOPMENT

A Care Plan shall be developed, in consideration with the Nutritional Evaluation, in an interactive process with each client of medical nutritional therapy services. Development of the Nutritional Care Plan is a translation of the information acquired during Intake and Assessment into specific measurable goals and objectives with defined activities and time frames to reach each objective. The Nutritional Care Plan outlines interventions and services that will meet the nutritional needs of the individual. The Nutritional Care Plan will include explanations of referral and follow-up and realistic objectives and goals to be achieved by program compliance. The client and Registered Dietitian or DTR will work together to decide what actions are necessary to accomplish each objective and who will take responsibility for each task.

The client and Registered Dietitian or DTR must mutually agree to all goals and objectives outlined in the Nutritional Care Plan. The Nutritional Care Plan will include the Registered Dietitian and client's signatures and date the Plan was signed. A copy will be maintained in the client's individual record. If an electronic medical record exists in lieu of a paper file, the Registered Dietitian or DTR will document in the client's electronic medical record that the Care Plan has been mutually agreed to by the client and the Registered Dietitian/DTR.

1: The nutritional care plan should be updated annually for active, on-going clients in the

program. All Care Plan updates must include the client's and Registered Dietitian's or DTR's signature with a copy maintained in the client's file.

2: The Registered Dietitian/DTR shall document that a client had a minimum of one HIV medical visit during the measurement year, a visit defined as having either a viral load or CD4 count lab test.

CARE PLAN IMPLEMENTATION

The Registered Dietitian (RD) or DTR shall be available to assist the client in facilitating access to services when needed and/or provide advocacy assistance to help problem solve as necessary when barriers impede access. The RD/DTR will always first attempt to encourage clients to resolve their challenges, and support clients in thinking through solutions before acting on behalf of the client to achieve nutritional care plan objectives. Referral agencies shall be assessed for appropriateness to client situation and need. The referral process shall include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements shall be considered as a part of the referral process. Any referral made shall be appropriately documented in the client record.

NUTRITIONAL CARE PLAN FOLLOW-UP AND MONITORING

Periodic Care Plan follow up and monitoring will be used to ensure that: 1) the care plan is adequate to meet client needs; 2) the client is actively pursuing Nutritional Care Plan objectives; 3) care is coordinated; and 4) changing or emerging needs are being addressed. The Plan should be signed and dated by both the RD/DTR and client at the time of each update, and placed in the client's record. If an electronic medical record exists in lieu of a paper file, the RD/DTR will document in the client's electronic medical record that the Care Plan has been mutually agreed to by the client and the RD/DTR at the time of each update.

The care plan should be updated annually during the measurement year, unless the client terminated services during the measurement year. If the care plan remains appropriate and no revisions are made, the RD/DTR should document that the care plan has been reviewed and no changes were indicated. It is recommended that clients indicate either acceptance or review of their care plan, regardless of whether changes were made.

REASSESSMENT

Clients receiving medical nutritional therapy services will have their needs reevaluated through reassessment which will be used to identify resolved issues, unresolved issues, and emerging need as compared to the prior assessment. Reassessment will guide appropriate revisions in the Nutritional Care Plan, and make informed decisions regarding discharge from medical nutritional therapy services and/or transition to other appropriate services. Reassessment will be conducted utilizing the same process outlined for initial assessment.

TRANSFER AND DISCHARGE

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

Conditions under which Transfer/Discharge is appropriate:

1. Client achieves self-sufficiency.
2. Death of the client
3. The client is relocating out of the service area
4. The client and/or client's legal guardian requests that the case be closed
5. The client is improperly utilizing the service
6. The client is found not to be HIV+

Conditions Under Which Transfer/Discharge May Occur:

1. Client proves proficiency in ability to navigate health and support services systems.
2. Client is "lost to follow-up" (defined later)
3. Client moves into a system of care which provides in-house medical nutritional therapy
4. Client moves out of the geographic service area
5. Client becomes self-sufficient or no longer meets financial guidelines
6. Client is unwilling to participate in Nutritional Care Plan as developed by the RD/DTR and client
7. Client exhibits a pattern of abuse towards agency staff, property or abuse of services
8. Client needs are more appropriately addressed in other programs (RD/DTR is responsible for ensuring that a smooth transition occurs)
9. Client provides false information or documentation.

Process for Transfer/Discharge

1. Reason for discharge or transfer is discussed with the client and options for other service provision is explored and documented (preferably face-to-face).
2. In instances where the RD/DTR agency initiates termination:
   (a) The RD/DTR shall consult with supervisor about their intent to discharge client.
   (b) The client is informed of intent to discharge and is provided with information regarding the appropriate appeals process of that decision.
   (c) The client is informed of other community resources available that may be able to meet their needs.
   (d) In some circumstances, a client may be suspended from services for a specified period of time. Document efforts made to assist the client in being successful in meeting expected program guidelines and becoming re-eligible for services.
3. Discharge Summary is prepared, which includes careful documentation of reason(s) for discharge and a service transition plan. Document efforts made to assist the client in being

successful in meeting expected program guidelines and becoming re-eligible for services.

Criteria

1. A client is considered "lost to follow-up" when a RD/DTR has made a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative. This can be done through any combination of phone messages, letters, provider contacts, or home visits.

Documentation

The Discharge Summary is included in the Progress Notes in the client's file.

Grievance Process

If the client disagrees with the termination of his/her medical nutritional therapy services, the case will be reviewed through the agency's specific grievance procedure.

Adopted: _____ Approved: 4/26/17

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Outreach Services Standard

No.: SSC 19
Date Approved: 12/08/10
Last Revised: 06/28/17
Date Reviewed: 06/28/17

Policy: The attached document represents the service standards to be utilized when providing outreach to people in the Sacramento TGA with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

As directed by the HIV Health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White funding is to be used for HIV/AIDS outreach services to identify people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services. As such, any outreach services which are paid for through Ryan White finding shall be related to assisting clients in accessing HIV healthcare or other social support service appointments related to maintaining healthcare (i.e. ADAP, Medi-Cal, etc).

2. Ryan White (RW) funding is to be expended in a cost effective, equitable manner. Outreach services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by a RW Agency.

3. PURPOSE OF OUTREACH SERVICES

The Health Resources Services Administration (HRSA) defines outreach services as programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Every effort must be made for Outreach programs to be delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at

disproportionate risk for HIV infection; be conducted at times and in places where there is high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Key activities include:

- Outreach to partners of positive people
- Distribution of safe sex kits to high risk communities
- Attendance at community awareness events to encourage testing
- Follow-up on referrals from Ryan White agencies of persons who have fallen out-of-care.

GOALS OF OUTREACH SERVICES:

The goal of outreach services is to promote access to and engagement in appropriate services for people living with HIV who:

- are aware or unaware of their HIV status, but are not currently in care (unmet need);
- have fallen out of care or are at-risk of falling out of care;
- are self-managed or those who don't utilize the continuum of care;
- promote communication and collaboration between the clients and all persons involved in the client's care;
- Educate the client on available resources and assist them in accessing those resources.

OUTREACH SERVICES EDUCATION REQUIREMENTS & TRAINING

All agencies shall comply with Health Resources Services Administration (HRSA) standards as well as all federal, state, and local requirements for certification and/or license.

At minimum, all outreach staff will possess the ability to provide linguistically and culturally appropriate services for people living with HIV, and complete documentation as required by their positions. Staff will be sensitive to the needs of persons of diverse life experiences, including substance users, persons with mental illness, transgender individuals and persons with co-occurring disorders and, ideally, will have prior experience working with the target population. It is imperative that outreach workers are well acquainted with the entire HIV service delivery system, especially primary medical care and case management services. Programs are urged to utilize outreach workers who demonstrate personal life experience in managing HIV and/or negotiating the local service delivery system.

4. Outreach staff at RW Agencies may, at any time, submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services

Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

5. Clients shall have the right to request a review of any service denial from the agency that denied the service. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file.

Adopted: Date 6/28/17

Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Health Education and Risk Reduction Services Standard

No.: SSC 20
Date Approved: 12/08/10
Last Revised: 03/28/18
Date Reviewed: 03/28/18

Policy: The attached document represents the service standards to be utilized when providing Health Education and Risk Reduction services to people in the Sacramento TGA. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

As directed by the HIV Health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psycho-social and support services which significantly improve access and adherence to such medical services. As such, any Health Education and Risk Reduction services which are paid for through Ryan White (RW) funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare (i.e. ADAP, Medi-Cal, etc.).

2. Ryan White funding is to be expended in a cost effective, equitable manner which is based upon verified client need and encourages self-empowerment of clients. Health Education and Risk Reduction services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council"), or through an alternative assessment process administered by a RW Agency.

3. The purpose of Health Education and Risk Reduction services is to reach HIV+ persons and/or their sex and/or needle-sharing partners that reside in the Sacramento TGA. The primary focus is on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s).

4. The goal of Health Education and Risk Reduction services is to assist HIV+ clients in Partner Services including but not limited to notifying, either directly or through provider-assisted methods, their past or current sex and/or needle-sharing partners of their potential risk for HIV infection. Partner Services (PS) assures that notified partners are offered appropriate counseling, referrals, medical follow-up (such as HIV antibody testing), and if positive, subsequent medical

evaluation, treatment, counseling, and referral to other services as needed.
5.

Activities should:

a. address the prevention and risk reduction needs of *specific* populations at risk for HIV infection due to their sexual and drug related high risk behavior
b. be culturally and linguistically appropriate for the targeted populations
c. focus on enhancing the skills and capacities needed to implement personal risk reduction strategies

5. Contracted Service Providers shall:

A. Offer Partner Services on a routine basis to all HIV positive clients, inform each client that receiving assistance in the referral of partners is voluntary and confidential and will be offered periodically, and Partner Services intervention can play an important role in their own health as well as their partner's.

B. Establish and implement policies and procedures which:

1. Ensure that referred clients receive timely, effective, and quality Partner Services that meets his/her special needs.

2. Incorporate and ensure compliance with ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code I012).

3. Ensure that Partner Services Counselors are trained in Partner Services Basic I "HIV Disclosure and Partner Services Training for Partner Services " conducted by the California Department of Public Health, SID Control Branch.

4. Ensure that Partner Services Counselors use the procedures outlined in "Guidance for Completing the Partner Information Form (PIF)" published by the California Department of Public Health, Office of AIDS, when conducting a Partner Services session.

5. Incorporate and ensure, to the extent possible, adherence to established *HIV Partner Counseling and Referral Services Standards and Recommendations* published by the California Department of Public Health, Office of AIDS, HIV Education and Prevention Services Branch.

C. Perform an intake process for each client meeting eligibility criteria for Ryan White services and shall reassess each client's eligibility for Ryan White funds every six months as required by HRSA. The intake process shall include determining the client's eligibility for Ryan White funded services, completing the Ryan White Intake Form, and providing the client with an orientation to

services. The intake process shall be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of lack of funding or available staff. Clients placed on a waiting list shall be provided with referrals to alternate Ryan White agencies if alternatives exist, and all waiting lists shall be reported to the Service Performance Monitor at the mandatory Service Provider Caucus meetings. Once funding or staff becomes available, clients placed on the waiting list shall be seen in order of need.

D. Maintain an individualized file for each client that contains documentation of all services provided, appropriate signed release of information forms, documentation of referrals to the COUNTY's Partner Services, when appropriate, and case notes documenting client contact and resource and referral follow-up.

E. Comply with "SSC 05 Eligibility & Fees for Ryan White Funded Services", "HIV Health Services Planning Council Current General Directives and Service Directives", and all other applicable Service Standards found in CONTRACTOR's *Ryan White Care Program Sacramento TGA Contractor's Orientation Manual.*

F. Document and track all:

1. Service provision to clients through the SHARE web-based database.
2. Referrals to outside County Partner Services.
3. Referrals and activities taken to follow-up with high-risk HIV-negative and HIV-positive clients.
4. Service provision to clients within two weeks of client encounter in the AIDS Regional Information and Evaluation System (ARIES) web-based database.
5. Current signed ARIES Share form.
6. Current signed Ryan White Release of Information Authorization

6. If available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients living with HIV/AIDS who rely on RW funded services. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

7. Ryan White Agencies may, at any time, submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services

Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

8. RW Agencies shall provide a means by which their staff can obtain in-servicing and on-call advice related to interpreting client medical needs.

9. Clients shall have the right to request a review of any service denials from the agency that denied the service. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file. .

Adopted: Susan Farrington Date 4-10-18
Susan Farrington, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Social Services Case Management Service Standards for Persons Living with HIV/AIDS

No.: SSC 21
Date Approved: 12/12/12
Last Revised:
Date Reviewed:

Policy: The attached document represents the service standards to be utilized when providing Social Service Case Management services to Ryan White eligible clients in the Sacramento TGA who are receiving Medical Model Case Management services by a non-Ryan White funded medical case management provider. This standard is to be used in conjunction with other Service Standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

As directed by the HIV Health Services Planning Council priorities, when funded, the following service standards will apply to Ryan White contracted service providers.

PURPOSE OF SOCIAL SERVICES CASE MANAGEMENT

The Health Resources Services Administration (HRSA) defines Social Services Case Management (non-medical) as services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services.

May include:

- Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private program for which they may be eligible
- All types of case management encounters and communications (face-to-face, telephone contact, other)
- Transitional case management for incarcerated persons as they prepare to exit the correctional system

Note: Does not involve coordination and follow up of medical treatments

The Sacramento Transitional Grant Area (TGA) views the goal of Social Service Case Management is to facilitate access and linkage to appropriate services within the continuum of care. Social Service Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors,

and evaluates options and services to meet individual's needs in a timely and appropriate manner. Social Service Case Management is an on-going process to empower clients by encouraging their ability to function independently.

FUNCTIONS OF CASE MANAGEMENT

It is the Case Manager's responsibility to:

- Offer accurate and current information to their client;
- Assist their client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions;
- Present options to the client from which he/she may select a course of action;
- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm; and
- Be available within work schedule to support and problem solve, and to not judge the client in the present or future based upon their decision(s) of the past;
- Gather and evaluate information from the client;
- In coordination with the client, create a care plan that addresses basic living needs, medical treatment and compliance issues, and other appropriate social service needs;
- Promote communication and collaboration between the clients and all persons involved in the client's care;
- Educate the client on available resources and assist them in accessing those resources.

CASE MANAGER EDUCATION REQUIREMENTS & TRAINING

1. The minimum education and/or experience requirements for case managers should be:
    a. Related experience for a period of 2 years of full time employment (or equivalent), regardless of academic preparation.
2. All Case Managers must complete training on the HIV Health Services Planning Council's approved Service Standards within 30 days of beginning employment. This does not preclude an employer's (contracted Ryan White provider) ability to provide other training to the Case Manager, as it deems appropriate and necessary.
3. Attendance at ongoing Case Management training opportunities organized by the Fiscal Agent and others as appropriate.
4. Case Managers must also be familiar or become familiar with health and human services available within the TGA, regardless of funding source.

CASE MANAGEMENT PROCESSES

After a referral for case management has been triaged among agency staff, the core activities of case management are:

- Intake
- Assessment
- Reassessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- Transfer and Discharge
- Evaluation of Client Satisfaction

INTAKE

Each prospective client who requests or is referred for Case Management services will be properly screened and evaluated through a face-to-face intake process designed to gather information for future service delivery and assist in decision-making regarding immediate needs. The service request/referral will be screened for basic admission criteria and assesses whether the client is in a crisis situation and/or requires immediate direct service referral. If immediate intervention is needed, the client shall be immediately referred to the appropriate entity.

At minimum, the following activities will take place during initial intake:

1. The Ryan White Program Intake form will be completed in its entirety.
2. The client will be assessed with an Acuity scale which will be dated and signed by the case manager. The acuity scale will be updated every 6 months.
3. The client's Informed Consent to Participate in the case management program shall be obtained.
4. The client will be informed of their right to confidentiality and information privacy procedures.
5. The client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities. Additionally, the Release of Information Form must be updated annually.
6. The client will be informed of, and agree to the Client's Rights and Responsibilities form.
7. The client will be informed of an agency's as well as the Ryan White Program's Grievance Procedure.
8. The client will be informed of the role and purpose of case management.
9. Assuming basic eligibility, the client may proceed to formal assessment, or be referred to another Case Management agency (if the client would be better served based upon their particular need for case management services).
10. Create a client file and archive all relevant documents and forms.

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services.

ASSESSMENT

Each client of Case Management services will participate in at least one (1) initial face-to-face interview with a Case Manager to assess their bio-psychosocial needs. The assessment will be used to collect, analyze, and prioritize information which identifies client needs, resources, and strengths for purposes of developing a Care Plan. Assessment will be conducted by a Case Manager and performed in accordance with written policies and procedures established by the individual Ryan White provider utilizing appropriate Ryan White Program forms (including the Client Intake Form), as required.

CARE PLAN DEVELOPMENT

A Care Plan shall be developed, in consideration with the Acuity scale, in an interactive process with each client of Case Management services. Development of the Care Plan is a translation of the information acquired during Intake and Assessment into specific measurable goals and objectives with defined activities and time frames to reach each objective. The Care Plan outlines interventions and services that will allow the client to overcome barriers and fulfill their needs, and identifies strategies and action plans for implementing those interventions and accessing needed services. The Care Plan will include explanations of referral and follow-up and realistic objectives and goals to be achieved by program compliance. The client and Case Manager will work together to decide what actions are necessary to accomplish each objective and who will take responsibility for each task.

The client and Case Manager must review and mutually agree to all goals and objectives outlined in the Care Plan. Following this process, the client and Case Manager must sign and date the Care Plan. If an electronic medical record exists in lieu of a paper file, the Case Manager will document in the client's electronic medical record that the CARE Plan has been mutually agreed to by the client and the Case Manager.

In accordance with US Department of Health Resources and Services Administration new performance measures:

1: The Care Plan must be updated two or more times during the measurement year, unless the client initiated services within six months prior to the end of the measurement year.

For example: The Sacramento TGA fiscal year is March through February. If a client entered services in December, only the initial Care Plan would be feasible during the measurement year of March – February.

2: The Case Manager shall document the client's HIV medical visits during the measurement year.

CARE PLAN IMPLEMENTATION

The Case Manager shall be available to assist the client in facilitating access to services when needed and/or provide advocacy assistance to help problem solve as necessary when barriers impede access. The Case Manager will always first attempt to encourage clients to resolve their challenges, and support clients in thinking through solutions before acting on behalf of the client to achieve care plan objectives. Referral agencies shall be assessed for appropriateness to client situation, lifestyle, and need. The referral process shall include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements shall be considered as a part of the referral process. Any referral made shall be appropriately documented in the client record.

CARE PLAN FOLLOW-UP AND MONITORING

Periodic Care Plan follow-up and monitoring will be used to ensure that: 1) the Care Plan is adequate to meet client needs; 2) the client is actively pursuing Care Plan objectives; 3) care is coordinated; and 4) changing or emerging needs are being addressed. The Care Plan should be signed and dated by both the case manager and client at the time of each update. If an electronic medical record exists in lieu of a paper file, the Case Manager will document in the client's electronic medical record that the Care Plan has been mutually agreed to by the client and the Case Manager at the time of each update.

The Care Plan must be updated two or more times during the measurement year, unless the client initiated services within six months prior to the end of the measurement year. If the Care Plan remains appropriate and no revisions are made, the Case Manager should document that the Care Plan has been reviewed and no changes were indicated. It is recommended that clients indicate either acceptance or review of their Care Plan, regardless of whether changes were made.

REASSESSMENT

Clients receiving Case Management services will have their needs reevaluated through a comprehensive psychosocial reassessment and acuity scale reassessment. Reassessment shall occur at a minimum of every six months. The reassessment will be used to identify current RW eligibility, resolved issues, unresolved issues, and emerging need as compared to the prior assessment, and will guide appropriate revisions in the Care Plan, and make informed decisions regarding discharge from Case Management services and/or transition to other appropriate services. Reassessment will be conducted utilizing the same process outlined for initial assessment.

TRANSFER AND DISCHARGE

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

Conditions Under Which Transfer/Discharge is appropriate:

1. Client achieves self sufficiency;

2. Death of the client;
3. The client and/or client's legal guardian requests that the case be closed;
4. The client is found not to be HIV+.

Conditions Under Which Transfer/Discharge <u>May</u> Occur:

1. Client proves proficiency in ability to navigate health and support services systems;
2. Client is "lost to follow-up" (defined later);
3. Client moves into a system of care which provides in-house Case Management;
4. Client moves out of the Case Manager's geographic service area;
5. Client becomes self sufficient or no longer meets financial guidelines;
6. Client is unwilling to participate in Care Plan as developed by the Case Manager and client;
7. Client exhibits a pattern of abuse towards agency staff, property or abuse of services;
8. Client needs are more appropriately addressed in other programs (Case Manager is responsible for ensuring that a smooth transition occurs);
9. Client provides false information or documentation.

Process for Transfer/Discharge

1. Reason for discharge or transfer is discussed with the client and options for other service provision is explored and documented (preferably face-to-face).
2. In instances where the Case Management agency initiates termination:
   (a) The Case Manager shall consult with supervisor about their intent to discharge client.
   (b) The client is informed of intent to discharge and is provided with information regarding the appropriate appeals process of that decision.
   (c) The client is informed of other community resources available that may be able to meet their needs.
   (d) In some circumstances, a client may be suspended from services for a specified period of time. Document efforts made to assist the client in being successful in meeting expected program guidelines and becoming re-eligible for services.
3. Discharge Summary is prepared, which includes careful documentation of reason(s) for discharge and a service transition plan. Document efforts made to assist the client in being successful in meeting expected program guidelines and becoming re-eligible for services.

Criteria

1. A client is considered "lost to follow-up" when a Case Manager has made a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative. This can be done through any combination of phone messages, letters, provider contacts, or home visits.

Documentation

The Discharge Summary is included in the Progress Notes in the client's file.

Grievance Process

If the client disagrees with the termination of his/her Case Management services, the case will be reviewed through the agency's specific grievance procedure.

If a resolution is not mutually resolved between the client and agency, then the case will be reviewed by the Fiscal/Administrative Agent (FAA) and a written response sent to all parties involved (e.g. agency, client) within twenty (20) working days with a disposition. If an extension is needed, a letter shall notify all parties involved of an extension for an additional ten (10) working days. Final disposition shall occur no later than thirty (30) working days following the initial filing with FAA.

Adopted: Kane R. Ortega Date: 12/12/12

Kane Ortega, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Health Insurance Premium and Cost-Sharing Assistance Program

No.: SSC 22
Date Approved: 09/24/14
Date Revised: 03/28/18
Date Reviewed: 03/28/18

Purpose:

Health Insurance Premium and Cost-Sharing Assistance Program services are designed to assist clients in paying their medical insurance premiums, deductibles and co-payments with the goal of preventing loss of access to medical care. This standard outlines a common approach to providing Health Insurance Premium Payment and Cost-Sharing Assistance Program services to eligible recipients in the Sacramento TGA and is to be incorporated with complimentary service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council.

1. Policy:

The Affordable Care Act requires all individuals to obtain minimal essential health care overage including but not limited to health insurance Marketplace plans; most individual plans bought outside the Marketplace; job-based insurance, including SHOP plans; Medicare; Medicaid; CHIP; TRICARE; COBRA. Some individuals may qualify for a health care coverage exemption. Those individuals who are not exempt and can afford coverage but choose not must pay a fee called the individual shared responsibility payment. It is the responsibility of all Ryan White CARE Act contracted service providers to facilitate enrollment of eligible clientele into an appropriate health care coverage plan and to apply Ryan White HIV/AIDS Program (RWHAP) funds as payer of last resort.

The provision of Health Insurance Premium and Cost-Sharing Assistance must be consistent with the United States Health Resources Services Administration's (HRSA) HIV/AIDS Bureau, the Sacramento TGA's Service Standards Policy 05 (SSC05) Eligibility and Fees for Ryan White Part A and B Services and Sacramento TGA's Health Insurance Premium and Cost-Sharing Assistance program.

Health Insurance Premium and Cost Sharing Assistance as defined by HRSA provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

If available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients living with HIV/AIDS who rely on RW funded services. Agencies shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

2. Established Standards:

A. To use RWHAP funds for health insurance premium and cost-sharing assistance, a recipient must implement a methodology that incorporates the following requirements:

- RWHAP funded recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics as determined by the United States Department of Health and Human Services (HHS) treatment guidelines [http://hab.hrsa.gov/deliverhivaidscare/clinicalguidelines.html] along with appropriate HIV outpatient/ambulatory health services

- RWHAP funded recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective

B. The provisions of the Health Insurance Premium and Cost-Sharing Assistance Program include but may not be limited to the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health services and pharmacy benefits that provide a full range of HIV medications for eligible clients

- Paying cost-sharing on behalf of the client used to offset any cost-sharing or deductible amounts that Medicaid programs may impose on a beneficiary

- Paying for Ryan White HIV/AIDS Program services not covered, or partially covered, by Medicaid.

- Paying a premium share of cost to prevent a lapse in coverage during the eligibility or transition period for enrollment into the State OA-HIPP program.

- In any circumstance where a client receives a refund of an over-payment as a result of a Ryan White payment, the client must return the overpayment to the Ryan White provider administering the Health Insurance Premium Payment and Cost-Sharing Assistance Program.

- Payments must be returned within 30 days, in the form of a cashier's check or money order, made payable to the Ryan White administering provider.

- Must be the payer of last resort

C. Recipients and sub-recipients should consider that some individuals are ineligible for premium tax credits and cost-sharing reductions:

- Clients under 100% FPL in states that do not implement Medicaid (Medi-Cal) expansion;
- Clients with incomes above 400% FPL;
- Clients who have minimum essential coverage other than individual market coverage (*e.g.*, Medicaid, CHIP, TRICARE, employer-sponsored coverage, and certain other coverage defined in Internal Revenue Code Section 5000(a)) available to them, but choose to purchase in the Marketplace; and
- Clients who are ineligible to purchase insurance through the Marketplace.

3. Ryan White funded agencies may, at any time, submit to the RW Fiscal Agent requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

4. RW funded agencies shall provide a means by which their staff can obtain technical assistance and on-call advice related to interpreting client medical needs.

5. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the RW Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file.

Signed: Susan Farrington
Susan Farrington, Chair

4-10-18
Date

State of California-Health and Human Services Agency

California Department of Public Health

2018 Comprehensive Health Care Coverage

All ADAP clients are strongly encouraged to enroll in health insurance.
ADAP can pay the premiums and outpatient medical out-of-pocket costs!

Are you a lawfully present California resident? Under the Affordable Care Act (ACA), California residents are able to obtain affordable health care coverage, regardless of any pre-existing conditions. Lawfully present California residents can obtain health insurance through Covered California.

When choosing a Covered California health plan, you should select the following metal tier, based on your income:
Silver - If your income is between $16,764 - $24,120* (139% - 200% FPL).
Platinum - If your income is $24,240 or higher* (201% FPL or higher).
(*For a family size of 1, based on 2016 FPL)
If you are eligible for an Advanced Premium Tax Credit (APTC), you must select the full amount to be applied to your premium.

For more information or to enroll, visit the Covered California website at www.CoveredCA.com or call (800) 300-1506. Please refer to the following list to find an ADAP site that also does Covered California enrollment: http://www.cdph.ca.gov/programs/aids/ Documents/ADAPandCCEnrollmentSites.pdf

If you don't get coverage, you may have to pay a tax penalty of $695 or 2.5% of your household income, whichever is greater!

Want to keep your doctor? Before selecting a health plan, contact your doctor's office to find out in which health plan network(s) they participate.

Not eligible to purchase insurance through Covered California? If you are not eligible for Covered California, a Medication Assistance Program enrollment worker may be able to assist you in enrolling in other health care coverage.

When can I enroll in health coverage? Open Enrollment for 2018 coverage for Covered California is November 1, 2017 through January 31, 2018. Special Enrollment periods occur within 60 days of a qualifying life event such as: a job loss, death of a spouse, birth of a child, became a new resident of the state, released from incarceration, etc. If you would like to enroll in a non-Covered California health insurance plan, please contact the health plan directly to inquire about their open enrollment period dates.

Get help paying for your health insurance costs! Once you enroll in a health insurance plan, you can enroll in the Office of AIDS Health Insurance Premium Payment (OA- HIPP) Program. The OA-HIPP program would pay for your:
Monthly health insurance premiums
Outpatient medical out-of-pocket costs up to the healthcare plan's annual out of-pocket maximum.
Talk to your enrollment worker for more information or call 844-421-7050.

I have been given information about health care coverage available to me. I understand that having health care coverage is required by law and that I may incur a financial penalty if I do not have comprehensive healthcare coverage.

Client's Signature: _____ Date: _____

☐ I have reviewed the information on this page with the client whose signature appears above.
Enrollment Worker initials: _____

Agency Name Here

SAMPLE RYAN WHITE CARE PROGRAM

CLIENT REFUND AGREEMENT

I, _____ am requesting assistance with insurance payments.
Client writes in name

I understand that the Ryan White Care Program is making the payment(s) on my behalf. Staff have explained to me the following:

_____ I might get a refund check from the insurance company.
Initials

_____ I might get a tax refund for the insurance payment from the IRS.
Initials

I understand that if I receive a refund, those funds must be returned back to the Ryan White Care Program in the form of a cashier's check or money order, within 30 days, by submitting payment to _____.

By signing below, I agree to the conditions above.

_____ _____
Signature Date

_____ _____
Witness Date