HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

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

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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:

- Nutrition assessment and screening;
- Dietary/nutritional evaluation and development of a nutritional plan at the first visit;
- Food and/or nutritional supplements per medical provider's recommendation; and
- Nutrition education and/or counseling.

Medical Nutrition Therapy services can be provided in individual and/or group settings outside of Outpatient/Ambulatory Health Services visit.

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

Medical Nutrition Therapy services are provided by dietitians licensed and registered in the State of California. Providers should be trained and knowledgeable in HIV-related issues. Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training

Initial: All Ryan White-funded staff providing Medical Nutrition Therapy must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including any continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

MEDICAL NUTRITIONAL THERAPY PROCESSES

Each new client enrolled in Medical Nutrition Therapy must receive an orientation to the services at the first visit; document this orientation in the client file.

The core activities of medical nutritional therapy are:

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

INITIAL 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 Dietetic Technician Registered (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:

- Baseline body weight.
- Medical History, including current medications, immunity, overall well-being, and any complications or other medical problems (i.e. diabetes, cardiovascular, kidney and liver diseases.
- Assessment of the client's nutritional status using a validated tool, such as the

HIV/AIDS Evidence-based Toolkit from the Academy of Nutrition and Dietetics.

- Documentation of a physician's recommendation if food or nutritional supplements are to be provided
- The Ryan White Program Intake form will be completed in its entirety.
- The client will be assessed by a Registered Dietitian utilizing an appropriate evaluation instrument within 30 days. The client's Care Plan will be reassessed as needed.
- 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.
- 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. Additionally, the 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 agency's Grievance Procedure.
- The client will be informed of the role and purpose of medical nutritional therapy.
- Create a client file and archive all relevant documents and forms.

Documentation: All client contacts, findings, education, and other information pertinent to client care must be recorded in the client chart.

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 timeframes to reach each objective. The Nutritional Care Plan outlines problems to be addressed, interventions and services that will identify and prioritize the nutritional needs of the individual. The Nutritional Care Plan will include explanations of referral and follow-up and realistic objectives and goals, and the frequency and duration of services to be achieved by program

compliance. The plan should include recommended services, course of medical nutrition therapy to be provided which includes the date, types and amount of nutritional supplements and food. 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 every six months 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 and date signed 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.

Treatment Provision: Medical Nutrition Therapy should be provided in a way that is consistent with the nutritional plan. All services including supplements or food provided should be documented in the client's chart.

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 every six months 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:

- Client achieves self-sufficiency.
- Death of the client
- The client is relocating out of the service area
- The client and/or client's legal guardian requests that the case be closed

- The client is improperly utilizing the service
- The client is found not to be HIV+

Conditions Under Which Transfer / Discharge May Occur:

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

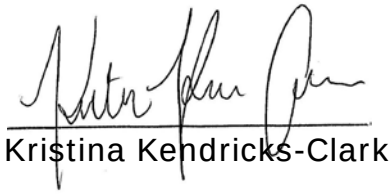
A client is considered "lost to follow-up" when a RD/DTR has made a minimum of three (3) good faith attempts within a 90-day period to contact the client, with no response from the client or his/her representative. This can be done through any combination of phone messages, letters, provider contacts,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

Signed:  Date: 02/26/20

Kristina Kendricks-Clark, Chair