COMMON STANDARDS

INLAND EMPIRE HIV PLANNING COUNCIL STANDARDS OF CARE RIVERSIDE / SAN BERNARDINO TRANSITIONAL GRANT AREA RYAN WHITE HIV/AIDS PROGRAM

Purpose of Standards

The Common Standards are standards that apply to all services. These include client eligibility and consent, provider qualifications and service delivery aspects. These are part of the Standards of Care that are approved by the Inland Empire HIV Planning Council (IEHPC) and pertain to clients of services and the agencies that provide the services funded by the Part A Ryan White Program (RWP) within the Riverside/San Bernardino Transitional Grant Area (TGA).

These standards are to be referenced in the contracts managed by the Ryan White Program and monitored and enforced by the Ryan White Program on behalf of the IEHPC, in conjunction with policies, guidance, and other requirements stipulated by the RWP legislation and the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA).

Overall TGA Impact

The IEHPC sets priorities for allocations of available RWP financial resources to services to address the needs of persons living with HIV/AIDS (PLWH/A) who are otherwise unable to access medical and support services that are necessary to maintain and improve their health. The goal is to address service gaps so that there is a comprehensive continuum of HIV/AIDS care in the TGA.

Services available to PLWH/A must be timely, comprehensive, client-centered, culturally and linguistically appropriate, and geographically accessible. The service system must also follow the chronic care model by fostering a provider base with resources and expertise, assisting and encouraging clients to take an active part in their care, and documenting service impact through evidence-based change concepts.

I. Client Eligibility Verification and Consent

All RW service providers must ensure that all individuals receiving RW-funded services meet all RW eligibility criteria. To qualify for eligibility for RWP-funded services, with the exception of clients receiving only Early Intervention Services (EIS), clients must provide verifiable information, as listed below:

A. Eligibility: Eligibility aspects must be verified to ensure compliance with Eligibility Criteria. HIV positive-status need only be verified once. Eligibility aspects that require verification at least every 6 months include proof of residence, income, insurance status, and payer-of-last-resort determination. HAB Policy #13-02 requires that, *"…at least once a year …the recertification procedures include the collection of more in-depth supporting documentation, similar to that collected at the initial eligibility determination."* The policy further clarifies that, *"…at one of the two required recertification's during a year, grantees may accept client self-attestation for verifying that an individual's…status complies with the grantee eligibility requirements. Appropriate documentation is required for changes in status and at least once a*

year."

ARIES Note: Some eligibility elements, such as HIV diagnosis, income eligibility, and residence eligibility, may be verified via the Eligibility screen in ARIES. If data in ARIES indicate that the individual's eligibility is up-to-date and that backup documentation is available at another Part-A funded agency, additional documentation does not need to be collected. Print out the Eligibility screen, circle the elements supporting current eligibility, and maintain in client's chart (paper or electronic). If ARIES data do not indicate up-to-date eligibility, the agency is required to collect the required documentation from the client before recording/invoicing the service delivery under the Part A contract.

1. **HIV Status:** Eligible individuals are HIV positive and must provide proof of their status. Proof consists of either:
   - A positive laboratory result that includes the individual's name and clearly indicates HIV+ status **OR**
   - A letter signed by a Physician, Physician Assistant, or Nurse Practitioner indicating that the individual is HIV+.

   Some services are available for affected family members and significant others**.** Services may be rendered to these individuals only when the service outcome directly and clearly impacts the health outcomes of the HIV positive client in a positive manner. Justification for service delivery to these individuals must be clearly documented.

2. **Residence:** Eligible individuals have resided in the TGA (Riverside County or San Bernardino County) for a minimum of 30 consecutive days. Annual proof of at least 30 days of residency in the TGA includes a letter/form signed and dated by the client that indicates address/location of residence and length of residency and **ONE** of the following indicating the client's name and address:
   - Current utility bill
   - Current rental or lease agreement Official document of some kind [e.g. current voter registration card, recent school records, property tax receipt, unemployment document, Lawful Permanent Residency (green card), prison release records (if recently released)]
   - California driver's license/California identification card Letter of residency verification signed and dated by an individual other than the client (e.g. roommate, landlord, parent)
   - For clients with unstable housing only (e.g. homeless), a detailed statement of residency verification signed and dated by agency staff that includes, in as much detail as possible, a description of the client's general location within the TGA and a declaration that the agency has recently referred the client to housing assistance services.

   If a client's residence has not changed since the previous recertification, client self-attestation that their residency continues to comply with eligibility requirements may be accepted as the mid-year recertification. If a client's residence has changed, appropriate supporting documentation is required. Agencies may require new clients to show proof of residency in the TGA for a longer period of time. This may not exceed 90 consecutive days.

3. **Income:** To be deemed eligible, individuals must meet the financial eligibility requirements as delineated by the IEHPC (*Financial Eligibility Criteria*). Supporting documentation related to ALL income sources must be provided. Documentation may include:
   - Two pay stubs
   - 1040 Form or W-2 from previous year
   - Signed and dated letter from source of earned income, on company letterhead if applicable, stating client name, rate and frequency of pay, company phone number, Two bank statements showing "income" from applicable source(s)
   - SSA, SSI or SSDI letter
   - Letter/document from some other form of government assistance (e.g. military/veteran pension benefits, unemployment benefits, child support payments)
   - Interest on investments
   - Letter of support signed and dated by individual providing financial and other living support (food, clothing, and/or shelter) to the client **AND** a letter/form signed and dated by the client that indicates zero income.

   If a client's income has not changed since the previous recertification, client self-attestation that their income continues to comply with eligibility requirements may be accepted as the mid-year recertification. If a client's income has changed, appropriate supporting documentation is required.

4. **Insurance Status:** To verify current insurance status, clients must submit all available documentation. This may include:
   - Copy of insurance card (be certain to indicate the date the copy was collected from the client)
   - Dated screen-prints/printouts of client insurance status verification through an official insurance screening system (such as the Medi-Cal system)
   - Statement signed and dated by the client indicating "no insurance", and if employed, reason why insurance is not available by employer.

   If a client's insurance status has not changed, client self-attestation that their access to/eligibility for insurance has not changed since the previous recertification may be accepted as the mid-year recertification. If a client's circumstances have changed, making them potentially able to access or eligible for a different insurance, appropriate supporting documentation is required.

5. **Screening for Other Funding Source:** RWP funds are to be used as funds of last resort. Therefore, eligible individuals must demonstrate that they are not eligible for and/or do not have access to non-Ryan White sources of funding (e.g., insurance and local, state, or federal programs, etc.) for the service for which they are applying. Verification documentation will vary depending on the service. Please refer to the specific service standards for other-funding verification requirements. Proof of eligibility for Ryan White funded services may include:
   - A denial/cancellation letter from other available resources (e.g., Medi-Cal, LIHP, CalFresh, HOPWA)

- A copy of current, official, policy language from the other source indicating circumstances of ineligibility that match the client's circumstances (example: "undocumented individuals are ineligible for food stamps")
- Documentation indicating that funds from another resource have been exhausted
- A letter/form signed and dated by the client indicating that they have no other resource for obtaining necessary/adequate service **AND** agency documentation indicating any other resources that were explored (example: referrals to food banks) and why these sources cannot adequately support the clients service needs, thereby requiring the use of Ryan White funded service.

Lack of access to/eligibility for other funding sources should be verified, when possible, on a point-of-service basis. If a client's access to/eligibility for other funding sources has not changed since the previous recertification, client self-attestation that their status has not changed may be accepted as the mid-year recertification. If a client's status has changed in any way, making them potentially eligible for another source, appropriate supporting documentation is required.

B. Consents and Notifications

1. **Consent for Service:** Individuals must indicate by signature that they consent to:
   a) obtaining services from the agency,
   b) case conferencing,
   c) referral to Outreach or some other equivalent program if they are suspected to have fallen out of care. NOTE: Consent must inform client that referral to one of these programs may result in the client being contacted using the contact information provided to the agency at intake,
   d) being informed annually of availability of partner services.

2. **ARIES Consent:** Individuals receiving Part A-funded services must indicate **every 3 years**, by signature, that they:
   a) agree to the use of ARIES, by the agency and by other RW-funded programs to which the client goes to for services, in recording and tracking any data relevant to the care and services provided to the client.
   b) agree to share select data and information contained in ARIES with other agencies that they receive services from in the Ryan White system of care.

3. **HIPAA Notification:** Individuals must indicate by signature that they have been notified of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA).

4.

C. Exceptions

1. Urgent Need: Every effort should be made to comply with the above eligibility requirements before providing RWP-funded services. However, there may be unusual circumstances in which a prospective client may have an urgent need for Ryan White funded services that require an expedited process. In these rare cases, exceptions may be made for prospective clients with urgent core service needs If an agency finds that it is necessary to exceed limitations specified in the service-specific Standards of Care (e.g. dental cap, housing duration, etc.) the agency must provide the RWP office with a written request for approval prior to exceeding the limitation. Only instances in which a client's health will be negatively impacted by NOT exceeding the limitation will be considered for approval. Therefore, the written request must clearly indicate the reason(s) the service delivery cannot wait until the following fiscal year and justify the medical need for exceeding the limitation.

   Action taken that is not communicated with the RWP will be considered in violation of eligibility requirements. Eligibility requirements must be met for subsequent service provision or, if the client is deemed ineligible, efforts must be made to refer the client to services funded by other sources and recoup expended RWP funds, if possible**.**

2. **Veterans:** According to HRSA Policy 07-07, *"Ryan White HIV/AIDS Program grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White HIV/AIDS Program services. Ryan White HIV/AIDS Program grantees (case managers, others) must work to assure that veterans receive necessary support or other services funded by the Ryan White HIV/AIDS Program that the VA health care system does not provide… Ryan White HIV/AIDS Program grantees or contractors may refer eligible veterans to the VA for services when appropriate and available. However, Ryan White HIV/AIDS Program grantees or contractors may not require that eligible veterans access VA care against their will."*

II. Client Rights

All eligible clients have the right to:

A. Request and receive approved services consistent with their care/treatment plan, the Inland Empire TGA Comprehensive HIV Services Plan, and subject to available funding.

B. Services that are reliable, timely, and appropriate to their situation, culture, health status, and their level of disability.

C. Be treated courteously and with appropriate sensitivity to compromised stamina, mobility, or other complications of their health status.

D. File a grievance with their service provider:

1. Grounds for Grievance/Complaint
   - **Denial of Services**: This means that even though the service is available and the client qualifies to receive it, it has been denied by

the agency. This does not include denial of service when an agency reduces services due to financial cutbacks.

- **Substandard Services**: This means that the agency is providing services that the client believes do not meet the Standards set forth by the Inland Empire HIV Planning Council (IEHPC).

2. If the grievance cannot be resolved at the provider level, the grievance may be forwarded to the RWP along with the written response from the agency documenting the issue and the attempts to resolve the issue (see current contract language concerning grievances).

E. Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities.

F. A selection of health care providers that is sufficient to provide access to appropriate high-quality health care.

G. Participate in decisions about their care and obtain information about treatment options.

H. Have their health care information protected and has the right to review and copy their own medical record and request that the physician amend the record if it is not accurate, relevant, or complete and insert the information or data that is accurate.

III. Client Responsibilities

Providers must inform all clients that they are responsible for the following:

A. Clients must provide appropriate documentation that verifies their eligibility for RWP Part A services (see *Section I: Client Eligibility Verification and Consent* above for details).

B. Clients must be involved in their healthcare and take responsibility for maximizing their health.

C. Clients must disclose relevant information and clearly communicate wants and needs.

D. As far as possible, clients should expect to make arrangements for services well enough in advance to avoid emergencies.

E. Clients consistently missing service appointments or consistently failing to adhere to their care/treatment plan should expect that the agency will refer them to more intense case management to explore the reasons and challenges contributing to their non-compliance. If client's compliance does not improve, a behavior contract, signed by the client and agency, may be established to delineate expectations and remedies. If client's compliance continues to be deficient, the agency may advise the client, as agreed upon in the behavior contract, that the client is subject to losing the privilege of future service.

F. Clients who by their behavior present an actual or potential danger of

interruption of service or creation of unsafe conditions for themselves or others may be refused service permanently or for a stipulated period of time. (This must be communicated to the client at the time of intake.)

G. Clients must maintain periodic contact (minimum = bi-annually) with a Medical Case Manager and/or Case Manager (non-Medical) to identify need for services documented in their care/treatment plan and update eligibility documentation.

H. Clients must follow reasonable Service Provider policies and guidelines to ensure fair, appropriate, and timely distribution of services to all eligible clients.

I. Follow written or verbal instructions meant to facilitate compliance with treatments or activities supportive of the care/treatment plan, protect their own safety, or improve the accessibility or utilization of services by themselves or other clients.

IV. Provider Requirements

A. Contracting Capacity: Service agencies or organizations must meet all standard Federal contracting requirements for all services provided under RW Program and must meet the requirements of contracts administered by County agencies or other County-approved contractors, whichever is more stringent. Service Provider must be compliant with all relevant OMB circulars. Where deficiencies have been noted regarding these requirements, the established action plan must be provided to the RWP and approved.

B. Staff Qualifications

1. All staff, including subcontractor staff providing services in lieu of directly-contracted staff, must hold the appropriate degrees, certification, licenses, permits, or other appropriate qualifying documentation, as required by the Federal, State, County or municipal authorities; as stipulated by the RWP; or as directed by the Inland Empire HIV Planning Council (IEHPC). See each specific service standard for detailed requirements by service.

2. Staff and volunteers providing direct services to HIV service clients will be expected to understand and appreciate the need for accessible, timely, appropriate, affordable and effective services as a prerequisite to comprehensive care and health maintenance.

3. Staff and volunteers providing direct services to HIV service clients should be culturally/linguistically competent, aware, and appreciative of the special physical and psychosocial needs of individuals infected with or affected by HIV and AIDS and will facilitate the maintenance of clients' health and quality of life.

4. Staff and volunteers of service provider contractors and subcontractors must at all times abide by and work to enforce city, county, state, and federal workplace laws, policies, procedures, and other requirements aimed at guaranteeing clients safety, full access and equity in services provided.

5. Those who are not formally employed by the agency (such as volunteers) are subject to the same requirements regarding client confidentiality. These individuals can provide services to clients only under the direct supervision of a fully trained staff member.

C. Staff Orientation and Training

1. All service provider staff or subcontractors who have contact with or make decisions about HIV service clients must, within three (3) months of hire, participate in a program of orientation and in-service training related to their job description and serving those with HIV. This may include requirements of health maintenance for persons living with HIV, HIV/AIDS-related disabilities, and client service expectations and preferences.

2. All service provider staff must receive a minimum of 8 hours annually of approved training as follows:

a) A minimum of 4 hours of service-specific training. For example, HIV/AIDS related trainings concerning:

- Medical Care
- Nutrition
- Outreach
- Mental Health
- Substance Abuse
- Housing
- Other service specific trainings related to providing services to HIV+ individuals
  - O Prevention with Positives
  - O Partner Services

b) A minimum of 4 hours of general HIV/AIDS training such as:

- AIDS 101
- Client Self-Management
- Cultural Competency
- Benefits Training
- Chronic Care Model
- Other trainings with advance approval from the RWP

3. Training “hours” can be received through various modalities, including, but not limited to:

- In-person (e.g. conferences, lectures, seminars)
- Articles
- Home studies
- Webinar

4. Conferences, home studies, webinars, and other similar modalities will be counted as direct “hours.” One page (typically 250 words) of reading not related to any other training modality (e.g., articles) will be equivalent to ten (10) minutes of “training.” Therefore, as an example, six (6) article

pages will count as an hour of "training."

5. Training hours for each staff member must be clearly documented and tracked for monitoring purposes.

D. Client Access: Service Providers will be responsible for planning and implementing services in a way that accommodates and facilitates an accessible environment to eligible users and potential users by taking affirmative steps to identify and meet the priority needs of clients, as well as providing adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments. Clients must be able to utilize services regardless of age, gender, sexual orientation, race, ethnicity, disability, geographical location of residence within the TGA, or other factors unrelated to qualification for service.

E. Service Management

1. Services will be managed in a way that is transparent, fiscally responsible, and accepting of the needs of all clients and removes barriers to clients' ability to meet the requirements of their care/treatment plans.

2. Services will be managed to achieve accessibility, effectiveness, reliability, timeliness and appropriateness to the needs of clients.

3. Reasonable effort will be made to ensure clients are not receiving duplicate services at another agency.

4. Where service provision options are substantially equivalent in meeting the health support needs of clients, the least costly alternative is preferred.

5. Services should be planned, managed, and monitored to avoid the need for urgent or emergency services, the interruption of services, and need for emergency or unplanned appropriations of funding to continue services during contract periods.

6. All clients must have, at a minimum, documented statements of need for all RW services delivered to the client that are updated annually and available for review. For clients requiring more intense, Medical Case Management coordination, service need for all care services (RW and non- RW) must be documented in a care/treatment plan that is shared with the client as well as all others involved in the client's care (e.g. physician, mental health provider, food voucher distributor, etc). Documentation must indicate, by client signature, that the care/treatment plan was discussed with the client annually and updated on an annual basis.

7. Case conferencing must occur annually for at least those clients requiring Medical Case Management care coordination.

8. Service providers will incorporate activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency. These may include, but are not limited to:

- Referrals to non-RW funded services
- Resource guides to low-cost/free medical and support services (both RW and non-RW)
- Budgeting activities to assist the client with financial planning

9. Service Providers will immediately refer clients to other providers if they cannot provide a level of service that is medically, culturally, linguistically, or otherwise appropriate and adequate for the health maintenance needs of a particular group of clients.

10. Direct-service and administrative staff will provide adequate data collection and documentation of all services provided for accounting, reporting, compliance, and evaluation purposes.

11. Service directors and managers will ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.

12. Service providers are encouraged to maintain a "client advisory group" that is representative of the population served and that provides input to the delivery of services. If provider does not maintain a client advisory board, providers must provide a suggestion box or other client input mechanism and conduct a client satisfaction survey, or focus group at least annually.

F. Service Documentation/Reporting

1. Service providers are responsible for documenting and keeping accurate records of service inputs, units of services, service outputs provided, client health outcomes, and complying with the collection of RWP minimum data elements as requirements for reimbursement of service expenses.

2. Reportable Units of Service (UOS): UOS are a component of each funded agency's contract. Please refer to the most current contract, including any amendments, for guidance regarding UOS.

3. Particular service performance indicators prescribed in the contract or presented in various policies throughout the contract period are considered integral to service contracts monitored by the RWP. Thus, all efforts to adhere to and collect data relating to these indicators are expected.

4. Summaries of anonymous service statistics from multiple service providers will be made available to the Planning Council by the Grantee for health service planning, budget oversight, and evaluation purposes.

5. All client records will be maintained in a confidential, locked location. Inactivated client records will be kept in a secure location for the period stipulated by law and by County contracts.

6. Documentation of all interactions, referrals and follow-up linkages with or

on behalf of the client must be entered into ARIES and may also be kept in a separate record/chart for each client. Activity that cannot be entered into ARIES (e.g. outreach encounters during which insufficient information can be collected to create an ARIES record) must be recorded and tracked by some other method (e.g. logs). Exceptions to this request must be noted indicating the cause or reason for the exception.

7. Services will be delivered as prescribed by the Standards of Service and Care and policies adopted by the Inland Empire HIV Planning Council and referred to in the agency services contract.

G. Service Evaluation

1. Each service provider is responsible for evaluating and reporting its performance relative to care standards.

2. Evaluation teams, operating under the authority of the RWP, will have access to various sources of service documentation in order to conduct client chart reviews, utilization review summaries, and other types of service audits, as needed.

3. Each Provider will comply with the process for the collection and examination of data related to client satisfaction. Each Agency will have a process to respond to the information obtained from clients and reported by the RWP.

4. Each Provider will develop an improvement process, as needed, based on the annual Client Satisfaction Survey and annual program monitoring.

5. All Providers shall maintain a grievance procedure, which provides for the objective review of client grievances and alleged violations of care and service standards. Clients will be routinely informed about, and assisted in utilizing this procedure and shall not be discriminated against for so doing.

6. The Provider will have a client complaint procedure, through which clients may address issues not appropriate to the grievance procedure. Complaints will be investigated, and responded to in a timely and respectful manner by the Agency.

H. HIPAA Compliance

1. All providers will comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All HIPAA regulations must be followed when interacting with or on behalf of the client as well as in record maintenance. All clients must be apprised of their rights under HIPAA and this must be documented in ARIES and in each client's chart with a signed form.

2. Agency employees and volunteers shall sign a confidentiality statement following completion of staff orientation/training on the subject of

confidentiality.

3. Clients will be educated regarding their right to confidentiality and provided with a document that expressly describes under what circumstances client information can be released and to whom.

I. Minority AIDS Initiative (MAI) Funded Service Provision

In addition to items IV A – H above, agencies awarded contracts under the Minority AIDS Initiative must:

1. Be located in or near the geographic area(s) where services are provided.

2. Have a documented history of providing service to the target population(s) to be served.

3. Have documented linkages to the target population(s), to help close the gap in access to services for highly impacted communities of color.

4. Provide services in a manner that is culturally and linguistically appropriate.

V. Client Inactivation

A. Clients may be inactivated from a service when an interdisciplinary case conference of relevant service providers has determined that the client can and/or should be inactivated. Examples of justification for inactivation include, but are not limited to the following:

1. Client is lost to follow-up after multiple documented methods to contact.

2. Client has failed to provide updated documentation of eligibility status after three (3) documented attempts.

3. Client's actions have put the agency, staff, and/or other clients at risk.

4. Client has requested to be inactivated.

5. Client is not actively engaged in seeking and remaining in medical care and has not been for one year or more.

6. Client no longer resides within the TGA.

7. Client is deceased.

B. Clients must be made aware of agency-specific policies regarding inactivation at intake.

C. Please refer to the RWP's Policy Letter regarding Case Inactivation.

D. Client should be referred to Outreach or some other equivalent program in an effort to bring the client back into care, <u>before</u> inactivation.