First Congregation United Church of Christ
Inland Empire HIV Planning Council
3041 North Sierra Way
San Bernardino, CA 92405
(909) 229-4399
Website: www://iehpc.com

Riverside/San Bernardino California Transitional Grant Area

Maxwell Ohikhuare, M.D.
County Health Officer Co-Chair

Curtis Smith
Community Co-Chair

Standards Committee

Thursday August 8, 2019
10:30 am – 11:30 am

Meeting Location	Teleconferencing Location***
First Congregational United Church of Christ 3041 N Sierra Way San Bernardino, CA 92405 (909) 229-4399	Desert AIDS Project 1695 North Sunrise Way Palm Springs, CA 92262 (760) 323-2118

This facility is in full compliance with the American with Disabilities Act of 1992

Agenda

10:30 am				
	1.	**Call to Order**		**C. Smith**
		• Roll Call* **(PS Staff)**		
		• Introductions		
	2.	**Approval of Agenda**		**C. Smith**
		2.1	Approval of 8.8.19 agenda	
	3.	**Approval of Minutes**		**C. Smith**
		3.1	Motion to Approve 5.23.2019 minutes A-1	
	4.	**New Business**		**C. Smith**
		4.1	Review and Discuss Service Unit Definitions A-2	
		4.2	Review and Discuss Financial Eligibility Criteria A-3	
	5.	**Public Comment**		**Members of the Public**
	6.	**Members Privilege**		**PC Members**

[1] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.

	7.	**Review of Actions Items**	**PC Staff**
		Staff will:	
	8.	**Agenda Setting**	**PC Comm-Chair**
	9.	**Next Meeting**	**C. Smith**
		First Congregational United Church of Christ	
		Inland Empire HIV Planning Council	
		3041 North Sierra Way	
		San Bernardino, CA 92405	
	10.	**Roll Call**	**PC Staff**
11:30 am	**11.**	**Adjourn**	**C. Smith**

[2] The agenda item may consist of a discussion and a vote. Public comments can be made prior to each Planning Council vote.

* Members must be present at both roll calls to receive credit for meeting attendance.

** Attachment was not available at time of printing but will be available at the meeting.

***Teleconferencing will be disconnected if there are no participants on the line after 15 minutes

Requests for special accommodations (e.g., language translation) must be received 72 hours prior to the date of the meeting. Contact PC Support at (909) 229-4399.

All meetings of the Planning Council and its committees are open to interested parties from the general public. Notices are posted in compliance with the California Brown Act. Information regarding Planning Council meetings, and/or minutes of meetings are public records and are available upon request from the Planning Council Support Staff by calling (909) 388-0426 or by visiting the website http://www.iehpc.org.

Servicos en Español: Notificación para servicios de intérprete deben de someterse setenta y dos horas de anticipo. Por favor llame (909) 229-4399.

Maxwell Ohikhuare, M.D.
County Health Officer Co-Chair

Curtis Smith
Community Co-Chair

Standards Committee A-1

Thursday, May 23, 2019
10:30 am – 11:30 am

Meeting Location	Teleconferencing Location***
First Congregational United Church of Christ 3041 N Sierra Way San Bernardino, CA 92405 (909) 229-4399	Desert AIDS Project 1695 North Sunrise Way Palm Springs, CA 92262 (760) 323-2118

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Attendance

Members	N. Lustre, C. Smith, K. Sellons, R. Romo, Z. Welden
PC Staff	B. Ramsey. R. Gonzalez, J. Jones
RWP	S. Swims
Public	Sign-in Sheet on File

MINUTES

10:53 am

1. Call to Order — **C. Smith**
Roll Call* **(PS Staff)**
- Introductions

Approval of Agenda[2] — **C. Smith**

2.1 Request made for a motion to approve the 05.23.19 Agenda

2.2 M/S/C: K. Sellons / Jorge Ruiz / Carried

3. Approval of Minutes[2] — **C. Smith**

3.1 Request made for a motion to approve 03.21.19 Minutes

3.2 M/S/C: K. Sellons / Jorge Romo / Carried

4. New Business

4.1 Develop Work Plan for Part A & B for Common Standards of Care to Review & Consolidation:

Discussion:

S. Swims: Correction: The recommendation to consolidate Part A & B Standards came from the Ryan White Program staff not the State.

B. Ramsey: What would be the benefit for the Council to pair Part A & B?

S. Swims: To alleviate consumer confusion on eligibility for services.

B. Ramsey: Request that RWP provide a list of what providers identify as

things the Committee might want to consider changing from the provider's POV as to what needs to be updated; the Committee can prioritize from there As well as look at Part B based on what the consultants review reveals.

C. Smith: Ask members of the Committee to review the Common Standards and Part B Standards by the August Meeting.

No Motions/No Voting

M/S/C: None

4.2 **Review and Discussion of Planning CHATT Training for Quality Management and Standards of Care** — **C. Smith**

B. Ramsey: HRSA's introduction to Council members the Planning Chatt's release of Training Module 7 which trains planning bodies how to improve the system of care. Helps to know its responsibilities and how to execute them. **C. Smith:** Urged members to become a member and participate in the Planning Chatt's training process of receiving training notification and signing into online training sessions.

No Motions/No Voting

M/S/C: None

5. **Public Comment** [1] — **Members of the Public**

5.1 None

6. **Member Privilege** — **PC Members**

6.1 J. Romo Informed Council about the Disability Rights of California organization that assist the public with social barriers related to disability.

6.2 C. Smith announced his agency's Office Meet and Greet iss on June 5th in Hemet

7. **Review of Action Items** — **PC Staff**

Staff will:

7.1 Request RWP to provide Provider input to use during Part B Standards review.

7.2 Re-agendize the review of the Standards of Care for Part B when consultant review complete.

7.3 Integrate the Planning Chatt Module 7 training in the review for pairing Part **A & B** Standard of Care**.**

Next Meeting

TBD

8. **First Congregational United Church of Christ**
Inland Empire HIV Planning Council
North Haskell Hall
3041 North Sierra Way
San Bernardino, CA 92405

	9.	**Roll Call***	**PC Staff**
11:30 am	**10.**	**Adjournment**	**C. Smith**

[3] Public Comments: Any member of the public may address this meeting on items of interest that relate to the Ryan White CARE Act by completing a speaker slip to indicate their interest in addressing the Planning Council. A three-minute limitation will normally apply to each member of the public who wishes to comment, unless waived by the Chair.

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SERVICE UNIT DEFINITIONS

SERVICE	UNIT OF SERVICE
Outpatient/Ambulatory Health Service	• For medical care: One 15 minute encounter • For emergency medication: One prescription Example: o 30-day supply of Med-A and 30-day supply of Med-B = 2 prescriptions = 2 transactions = 2 units o 15-day supply of Med-C = 1 prescription = 1 transaction = 1 unit
Oral Health Care	• One 15 minute encounter
Mental Health Services	• One 15 minute encounter
Medical Case Management	• One 15 minute encounter
Substance Abuse Services (Outpatient)	• One 15 minute encounter
Home/Community Based Health Svcs	• One 15 minute encounter
Early Intervention Services	• For Encounters • One 15 minute encounter • For Tests • One Test / Confirmatory Test
Case Management (non-Medical)	• One 15 minute encounter
Medical Transportation Services	• One transaction (regardless of $ amount) • One taxi payment (one way) • One van trip (one way) • One bus voucher • One gas voucher
Food Bank/Home-Delivered Meals	• $10 transaction (regardless of $ amount) Example: o One $10 voucher = 1 unit o Four $10 vouchers = 4 units o One $20 voucher = 2 units o One $10 food bag = 1 unit o One $20 food bag = 2 units
Psychosocial Support	• One 15 minute encounter
Housing Services	• For Housing Case Management Services: One 15 minute encounter • For Housing Services (Financial Assistance): One day Example: – 5 nights hotel/motel (regardless of $ amount) = 5 days – One month's rent = 30 days

Ryan White Program (Part A and Part A MAI)
Financial Eligibility Criteria

***NOTE: Please refer to the entire set of Standards of Care for complete eligibility criteria.	
CORE SERVICE CATEGORY	**FINANCIAL ELIGIBILITY CRITERIA1**
Outpatient/Ambulatory Medical Care	**Total Income < 400% > of Federal Poverty Level**
AIDS Pharmaceutical Assistance (local)	**Total Income < 400% > of Federal Poverty Level**
Oral Health	**Total Income < 400% > of Federal Poverty Level**
Home and Community Based Health Services	**Total Income < 400% > of Federal Poverty Level**
Mental Health	**Total Income < 400% > of Federal Poverty Level**
Medical Case Mgmt. (Including tx adherence)	**Total Income < 400% > of Federal Poverty Level**
Substance Abuse Outpatient	**Total Income < 400% > of Federal Poverty Level**
Early Intervention Services	**Total Income < 400% > of Federal Poverty Level**
Medical Nutrition Therapy	**Total Income < 400% > of Federal Poverty Level**
SUPPORT SERVICE CATEGORY	
Case Management (Non-Medical)	**Total income < 300% > of Federal Poverty Level**
Emergency Financial Assistance	**Total Income < 300% > of Federal Poverty Level**
Food	**Total income < 150% > of Federal Poverty Level**
Housing Services	**Total Income < 300% > of Federal Poverty Level**
Medical Transportation	**Total income < 200% > of Federal Poverty Level**
Psychosocial Support	**Total income < 200% > of Federal Poverty Level**

1 Federal Poverty Guidelines:

- Refer to the most current poverty guidelines at http://aspe.hhs.gov/poverty.
- In the Riv/SB TGA, the Federal Poverty Guidelines should be applied to a "family".
- "Family" is defined by the Department of Health and Human Services as "a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family."
- If an individual does not fit this definition, and is not in a legal, domestic partnership, their income may be considered a separate "family" income.

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

d) 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,
e) 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*

3. *<u>services.</u> 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

7. 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.

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

9. 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

10. 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.

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

12. 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.

13. 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, before inactivation.

Standards of Care

Common Standard

Early Intervention Services

Food Bank - Home-Delivered Meals

Health Education Risk Reduction

Hospice Services

Housing

Linguistic Services

Medical Case Management

Medical Nutrition Therapy

Medical Transportation

Mental Health Services

Non-Medical Case Management

Oral Health

Other Professional Services

Outpatient Ambulatory Health Services

Outreach

Psychosocial Support Services

Referral for Health Care and Support Services

Substance Abuse Outpatient Care

Substance Abuse Services (residential)

Common Standards of Care

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	*OA Workgroup*	*6/10/2018*	*Marjorie Katz*	*6/10/2018*	*First public working draft*

TABLE OF CONTENTS

Introduction

This document describes the "Common Standards of Care" for all services of HIV Care Program (HCP), a program of the California Department of Public Health, Office of AIDS (OA), funded through the Ryan White HIV/AIDS Program (RWHAP) Part B. This document highlights each of the requirements and standards that must be followed by any provider receiving HCP (Ryan White) funding. Common standards addressed here include client eligibility and consent, staffing, cultural and linguistic competency, service management and closure, and quality assurance. These standards must be met or exceeded for all HCP services in all jurisdictions. Users should refer to service category-specific standards for more detailed or additional requirements.

How This Document is Organized

Within this document, the Common Standards of Care are described in terms of (1) Use of HCP Funds, and (2) Requirements.

Use of HCP Funds

1. All clients served by providers funded by HCP shall receive services that:
    - Are accessible to all persons living with HIV who qualify and meet eligibility requirements
    - Include a comprehensive intake process that establishes client eligibility, collects client information, and comprehensively informs them about available services
    - Maintain the highest standards of care, including providing experienced, trained, and (as appropriate) licensed staff
    - Are culturally and linguistically competent
    - Guarantee client confidentiality, protect client autonomy, and protect the rights of persons living with HIV
    - Promote continuity of care, client monitoring, and follow-up
    - Ensure a fair process of grievance review and advocacy
2. Providers must make reasonable efforts to secure non-RWHAP funds whenever possible for services to eligible clients (i.e., Ryan White must be the "payer of last resort").

3. HCP funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with HCP funds and the intended client's HIV status.

4. Affected individuals (partners and family members not living with HIV) may be eligible for HCP services in limited situations, but these services for affected individuals must always directly benefit people living with HIV. For more information see HRSA PCN 16-02 and ARIES Policy Notice C5.

Requirements

All service providers receiving funds to provide HCP services are required to adhere to all standards described in this *Common Standards of Care*. In addition, they must adhere to any service category-specific standards described in the standard of care for that service category. Monitoring is conducted on a yearly basis through desk review and onsite monitoring.

ARIES - AIDS Regional Information & Evaluation System

ARIES is a centralized, secure, online HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers throughout California to plan, manage, and report on client data. HCP frequently uses ARIES to conduct monitoring of these Standards of Care.

Intake

Client intake consists of four key steps:

- Eligibility screening
- Consents and notifications
- Client registration
- Screening for service needs / acuity

Eligibility Screening

The certification process verifies that a client's HIV status, residency, income, and insurance status meet eligibility requirements and ensures that HCP is the payer of last resort. Initial eligibility certification includes documentation of the following:

- **Proof of HIV-positive status:** At the first certification, clients must provide proof of HIV-positive status. This must consist of at least one of the following:
    - HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.
        - ***NOTE:*** *Rapid linkage to care after diagnosis is a top priority and this is not intended as a barrier; while agencies must have proof of HIV diagnosis and eligibility established before providing HCP-funded services, there is no legislative requirement for a "confirmed" HIV diagnosis prior to care (i.e. initial HIV screening test results is sufficient, though confirmatory testing should be ordered on first visit. See clarifying letter from HRSA on this issue).*
    - Letter from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead with the National Provider Identifier (NPI) number or California license number, and the physician's or a licensed health care provider's signature verifying the client's HIV status.
        - Letters already in client charts that do not meet this standard are grandfathered in; this requirement for letters applies to new intakes conducted after April 1, 2018.
    - Diagnosis Form (CDPH 8440) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.
- **Proof of Residence:** Individuals eligible for HCP services must reside in the State of California. Acceptable residency verification consists of the client's name and address on one of the following:
    - Current utility bill
    - Current rental or lease agreement
    - Official document, such as a voter registration card, Medi-Cal beneficiary letter, recent school records, property tax receipt, unemployment document, etc. ○ California driver's license or California Identity Card

- Letter from a shelter, social service agency, or clinic verifying individuals' identity, length of residency, and location designated as their residence. The letter must be on letterhead and signed by a staff person affiliated with the service agency or clinic
- If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates they are homeless with no connection to any other service provider. In this situation, a referral to assist the client in securing shelter or housing should be a priority. For an example of an affidavit form see the ADAP form CDPH 8727 / CDPH 8727 SP.

- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. HCP financial eligibility matches the financial eligibility defined by ADAP in Health and Safety Code (HSC) § 120960. Currently, HSC § 120960 defines income eligibility as clients with modified adjusted gross income which does not exceed 500 percent of the federal poverty level per year based on family size and household income. Acceptable income verification includes one of the following: ○ One pay stub from within the last 6 months ○ 1040 Form or W-2 from the previous year

  - Signed and dated letter from a source of earned income, including the client's name, rate, and frequency of pay
  - One bank statement showing income from applicable source(s) (i.e. through direct deposit)
  - Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) letter, or dated screenshots of client benefit program ○

  Document confirming other government assistance (e.g., Medi-Cal military/veteran pension benefits, unemployment benefits, child support payments)

  - Investment statement showing interest earned
  - Letter of support signed and dated by an individual providing financial and other living support (food, clothing, and/or shelter) to the client
  - If no other methods of verification are possible, letter, form, or affidavit signed and dated by the client that indicates zero income, or attests to earned

income not otherwise confirmed by the above. For an example of an affidavit form see the ADAP form CDPH 8441/ CDPH 8441 SP.

- **Insurance Status:** Clients seeking any services through HCP programs must provide documentation of health insurance status. Acceptable verification includes one of the following: ○ Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable ○ Dated screenshots of client insurance status verification using an official insurance screening system
  - ○ Denial letter from Medi-Cal
  - ○ Tax statement documenting no insurance, per ACA requirements ○ Statement signed and dated by the client indicating they are not covered by insurance. If client is employed, the statement must include the reason the employer does not provide insurance
- **Documentation of Need:** In order for providers to pay for services covered or partially covered by Medi-Cal, Denti-Cal, private insurance, or other eligible benefits and retain HCP as the payer of last resort, client charts must include the following:
  - ○ A description of the need for additional medically necessary services, beyond what the client's health care coverage or other benefits provide
  - ○ Documentation indicating that such services are only partially covered or unavailable in a timely fashion through the client's health care coverage or other benefits

  NOTE: *Contractors* and providers *should be aware that HCP funds cannot be used to pay for services provided by a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.*

  REMINDER: All HCP providers who provide services that overlap with Medi-Cal or Denti-Cal must be certified to receive Medi-Cal or Denti-Cal payments or are able to document efforts under way to obtain such certifications.
- **Screening for Service Needs / Acuity:** At the time of client intake into any HCP service, the client shall be screened for the need for other services, including but not limited to: medical care, case management, housing, food, mental health, substance use issues, transportation, and benefits counseling. Screening for services and client acuity can be done using the tools and/or scales of the local jurisdiction, but

tools/scales must be standardized within the jurisdiction. Referrals should be made for any services identified as needed but not offered by the screening agency; referrals should be performed utilizing a warm hand off when possible. All referrals must be documented.

Exceptions

In the case of clients with urgent/emergent service needs, it is acceptable to begin providing services having only obtained proof of HIV diagnosis (initial HIV screening test is acceptable per HRSA) and signed consents (see below); in these cases, full eligibility screening and all other requirements must be met within 30 days of service initiation. If this occurs, documentation in the client chart of the circumstances around the need for urgent/emergent services is required.

***Monitoring* Eligibility Screening -** Client eligibility, including HIV-positive status, residency, income, and insurance status must be entered into ARIES. Documentation of service needs and acuity must be documented in client chart(s), and made available during site visits. **ARIES Reference**

Proof of Diagnosis
- Eligibility Tab
- Eligibility Documents Sub-tab
- Pick one:
  1. HIV Letter of Diagnosis
  2. Proof of Diagnosis
- Upload copy of corresponding document
- *ARIES Policy Notice No. C3*

Residency
- Eligibility Tab
- Eligibility Documents Sub-tab
- Pick one:
  1. Picture ID
  2. Proof of Residency

Income
- Eligibility Tab
- Financial Sub-tab
- Enter:
  - Household Monthly Income
  - # of People in Household

Insurance
- Eligibility Tab
- Insurance Sub-tab
- Click *New*
- Enter:
  - Start Date
  - Source
  - Payer
- *ARIES Policy Notice No. C4*

Consents

Prior to receiving services, clients must sign the following consent forms:

- **Agency Consent for Service:** Clients must sign a consent form indicating they consent to receiving services from the agency
- **ARIES Consent:** Providers must obtain a completed ARIES Consent Form for each client and log the form into the Eligibility Documents screen in ARIES. Clients must indicate whether they want to share their ARIES data with other ARIES-using agencies at which they receive services. Information shared may include demographics, contact information, medical history, and service data. However, data related to mental health, substance use issues, and legal services are never shared between service providers regardless of the client's share choice.
    - The form must be renewed once every three years or whenever clients want to change their data-sharing choice. For more information, refer to ARIES Policy Notice C1 on Client Consent and Share Options.

On an as-needed basis, the following must also be documented via forms signed by the client:

- **Consent to Release Confidential Information (not the same as ARIES Consent Form):** When disclosure of confidential information is requested by the client, or

required for care coordination or other necessary components of high-quality service provision, the client must be informed of this intent to share information and must provide written consent before the information is shared. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.

- **Authorization to Exchange Confidential Information (not the same as ARIES Consent Form)**: Similar to the consent to release confidential information, when appropriate, clients may also provide consent for regular exchange of information about their case between providers as it helps with care coordination. Again, the client must provide written consent **before the information is shared**. All documentation of consent to release confidential information should specifically note what information can be shared, to whom it may be shared, and the time-limit within which the sharing may take place.
    - *NOTE:* Case conferencing between staff of the same organization which takes place on a regular basis and is a standard part of many HCP services does not require additional authorization. However, if staff from outside the organization are needed to conduct thorough case conferencing, prior authorization to exchange information would be required.

All signed consents must be kept in the client's file, and the client must receive a copy.

Monitoring **Agency Consent for Service** -

Signed consent forms shall either (1) be uploaded to ARIES, or (2) retained in client chart(s) and available for review upon request. **ARIES Consent -** ARIES Consent Forms must be logged into ARIES and the Share option must reflect the client's choice as reflected on the form. For more specifics, see ARIES Policy Notice C1.

Authorization to Exchange Confidential Information - Documentation of consent to release or exchange confidential information must be retained in client chart(s) and available for review upon request.

ARIES Reference

ARIES Consent Form
Eligibility Tab
Eligibility Documents Sub-tab
Pick ARIES Consent Form / Enter date

Share Option
Agency Specifics Tab

Agrees to Share Date / Select Yes or No

Notifications

As a part of HCP services, clients should be notified of the following:

- **Case conferencing** among staff involved in the provision of any of their care occurs regularly as a standard part of HCP services
- **Re-engagement services** are routinely provided by this provider and/or the county health department to ensure that clients have uninterrupted access to care services. This requires sharing of contact information as needed for these services
- **After-hours or weekend options** that are available to clients during an emergency (i.e. an on-call number, answering service, or alternative contacts in other agencies)
- **HIPAA:** Clients must be informed of their health information privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) where applicable
- **Client Grievance Procedures:** Clients must be informed of the grievance procedures within their local jurisdiction, and assured that no negative actions will be taken toward them as a client in response to their filing of a grievance
- **Client Rights and Responsibilities**: Clients must receive notice of their rights and responsibilities relative to HCP service provision. This must include the minimum rights and responsibilities outlined later in this Common Standards of Care document.

Clients must receive a written copy of all notifications provided during intake.

Monitoring **Client Notification** - Client notification of case conferencing, re-engagement services, and after-hours / weekend emergency options must be documented through submission of agency written policies and procedures and forms related to these notifications. **Client Notification with Signature** - Client notification of HIPAA, client grievance procedures, and rights and responsibilities must be documented in client chart(s) and available upon request for review. There must be documentation that the client has received these notifications; documentation shall be through client signature that they have received and acknowledged these notifications.

Client Registration into ARIES

HCP providers must report on the HCP clients they serve using ARIES.
For new clients, HCP providers must explain the "share" options to the client and obtain a signed ARIES Consent Form (see ARIES Policy Notice C1). Providers shall also collect the

client's identifiers to initiate client registration in ARIES. Identifiers include all of the following:

- First Name
- Middle Initial
- Last Name
- Mother's Maiden Name (see **ARIES Policy Notice C2**)
- Date of Birth
- Current Gender

To initiate ARIES registration, the HCP provider enters these identifiers into ARIES. If the client already exists in ARIES as a share client, ARIES will open the existing client record for the provider. If the client is non-share or new to ARIES, ARIES will create a new client record for the provider.

While the client is enrolled in the agency, the HCP provider is required to collect and enter into ARIES certain data elements for the annual Ryan White Services Report (RSR). These data elements are identified with large red asterisks in ARIES. For more details about and provider requirements for the RSR, please visit https://careacttarget.org/category/topics/ryan-white-services-report-rsr.

Timeframe

Intake appointments for new clients should be made as soon as possible to avoid potential drop out. Appointments must occur no later than 10 calendar days from first client referral. A referral can be from another professional or self-referral. Agencies must have a tracking method to record when first contact was made so it can be entered in to ARIES. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours as client missed appointments have been linked to future poor health outcomes. Missed appointments and attempts to reschedule must be documented in the tracking log or the client chart. For appointments made later than 10 days from first client referral, the reason for the delay must be documented in the client chart.

***Monitoring* Timeframe** for intake appointments for new clients will be monitored through site visit discussions regarding MOUs with referring agencies and internal processes. For those who do not have an automated system to track new referrals, a log of such referrals must be kept and available for review.

ARIES - data must be recorded for ARIES fields *Referral Date, Agency Enrollment Date,* and *Service Date.* Reasons for any delay in intake appointments beyond 10 days – or any exceptions made for urgent/emergent services per above – must be documented in client chart(s) and available for review upon request.

ARIES Reference

Demographics Tab	Services Tab
Agency Specifics Sub-tab 1. Step One, enter:	Enter date of first service

- Referral Date (date of first contact)
- Referral Source
- Other

2. Step Two, enter:
   - Agency Enrollment Date

Recertification

Eligibility recertification must be repeated at least every six months. At the six-month recertification, a client can self-attest that they continue to meet the established guidelines by signing a form with an appropriate statement. However, complete eligibility documentation is required 12 months after the initial intake or last annual recertification. (for an example of a self-attestation form see the ADAP form CDPH 8723 / CDPH 8723 SP):

- **Proof of Residence:** Continued proof of California residency must be documented. Acceptable residency verification is the same as that required for initial eligibility certification.
- **Income:** Clients must provide documentation of all forms of income and meet the income requirements. Acceptable income verification is the same as that required for initial eligibility certification.
- **Insurance Status:** Clients must provide documentation of health insurance status. Acceptable verification is the same as that required for initial eligibility certification.

Screening for Service Needs / Acuity: At least every six months, all clients must be reassessed for service needs and acuity level. Screening can be done using the tools and/or scales of the local jurisdiction, but these tools/scales must be standardized within the jurisdiction and documented in the client chart. Services provided to that client should be adjusted according to any changes in client needs/acuity since the last assessment.

***Monitoring* Six-Month Recertification -** Eligibility recertification of residency, income, and insurance status must be documented at least every six months. Client self-attestation forms can used for six-month recertification and can be uploaded to ARIES or saved in the client file. **Annual Recertification** - Annual recertification of residency, income, and insurance status must be documented in ARIES. Agencies must have updated documentation of these elements in client chart(s), available for review upon request. **ARIES Reference**

Step One:	Step Two:
Go to Eligibility Tab Update information on all three sub-tabs information as needed (see eligibility section above, Note "recertification" in comment field. HIV Diagnosis does not need to be repeated)	Go to Program Tab, Ryan White sub-tab Enter recertification date and

Upload self-attestation (optional)

Service Access, Management, and Closure

Client Access

Services must be planned and implemented in a way that ensures an accessible environment. Services must:

- Provide adequate accommodation for actual or potential physical, psychological, and psychosocial disabilities and/or impairments
- Not be restricted on the basis of age, gender, sexual orientation, race, ethnicity, disability, past or current health condition, ability to pay fees, residence, or any other discriminatory factors, as applicable, under the California Unruh Civil Rights Act and Disabled Persons Act (except as required for eligibility purposes.)

Service Management

Services must take into account client needs and remove barriers to clients' ability to meet the requirements of their care/treatment plans, as follows:

- Services must be managed to achieve:
    - Accessibility ○ Effectiveness
    - Reliability ○ Timeliness
    - Appropriateness to the needs of clients

***Monitoring* Accessibility** - Existence of adequate physical accommodation(s) for disabilities and/or impairments of clients, will be verified during site visits.

- Services must include activities and educational resources that promote, facilitate, and encourage client self-management and self-sufficiency, including but not limited to:
    - Access to non-HCP-funded services
    - Resource guides to low-cost/free medical and support services, including those not offered as part of HCP

In addition, services must be transparent and fiscally responsible:

- Services should be planned, managed, and monitored to avoid the need for:

- Urgent or emergency services ○ Service interruption
- Needing emergency or unplanned funding to continue services during contract periods.

- Data collection and documentation of all services must be manually entered or imported into ARIES for accounting, reporting, compliance, and evaluation purposes. The optimum goal for entering data into ARIES is in real-time. Some providers may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Providers that are unable to enter data in real-time have up to two weeks from the service date to enter the data. For more information, please see ARIES Policy Notice E1.
- Program directors and managers shall ensure contract compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.

- Service providers must have a way to obtain client input and feedback on an annual basis. The ideal method would be a "client advisory board" that consists of representation of the population served and provides input to the delivery of services. In lieu of an advisory board, providers can provide a visible suggestion box which is locked or other similar client input mechanism such as client satisfaction survey.

Monitoring

Client Input – copies of minutes from annual client advisory board meetings, or client suggestions or surveys will be reviewed during site visit.

Case Closure

In some cases (e.g. a client who is incarcerated for longer than 6 months) a client file may be made "inactive," able to easily be returned to "active" status when the client returns to services as expected. A client file may be permanently "closed" under certain conditions. The reason for and circumstances around all closure actions must be documented in the client file or in ARIES. Acceptable reasons for client file closure are:

- The client has requested transfer of services to another agency
- The client has died or moved out of California ○ Providers are strongly encouraged to report clients who have died or moved out of California to the HIV surveillance coordinator at the local public health department. This will allow the coordinator to

update the surveillance system and ensure that the county's data accurately reflect who is in care.

    - Providers should attempt to assist the client with identifying a source of care in the jurisdiction they are moving to.

- The client is lost to follow-up if the client cannot be located after at least three documented attempts per month over a period of three consecutive months. Attempts to contact the client must take place on different days and times of the day during this time period.

    - Providers are strongly encouraged to refer clients who are lost to follow-up to the local public health department for further outreach and re-engagement in care activities.

- The client is no longer eligible or has failed to provide updated documentation of eligibility status

    - Providers must be proactive in helping clients obtain this information. No client should be discharged before staff have assisted the client with gathering the required documentation.

- The client's actions have put the agency, staff, and/or other clients at risk
- There is evidence of client fraud or deliberate misuse of services
- Additional service-specific circumstances for closing a client file may be found in the Standard of Care for an individual service.

File Closure: Agencies should close a client's file according to the written policies and procedures established by the agency.

- **Prior to closure** (for reasons other than death), the agency must attempt to inform the client of the appeal process and re-entry requirements into the system, make clear to the client the consequences of closing the case, and offer to facilitate transfer of information to a new provider.
- **Prior to forced disenrollment and case closure due to evidence of abusive behavior, client fraud, deliberate misuse of services, or service ineligibility**, the

client must: ○ Be given at least 10 days' notice before disenrollment, except in cases of abusive behavior that poses serious physical danger to staff or clients

- Be sent a letter that verifies the disenrollment date and reason for the action, along with information about the procedure for grievance/appeals. This letter must be legible, signed, and dated, and a copy must be kept in the client record

Record Maintenance: Client files must be retained in a secure place for a minimum of three years, or later as is required by law for your facility type, after a case is closed. After that time period, they must be disposed of securely through confidential means such as cross cut shredding and pulverizing.

***Monitoring* File Closure** - Appropriateness of file closure will be monitored via chart review during inperson site visits. Agency policies and procedures for file closure, as well as compliance with record maintenance standards, will be monitored through agency submission of applicable written policies and procedures.

Client Rights and Responsibilities

Information in this section must be included in a client Rights and Responsibilities form. Clients must sign an acknowledgement of having received this information.

<u>All eligible clients have the right to:</u>

- Request and receive approved services consistent with their care/treatment plan
- Receive services that are reliable, timely, respectful, and appropriate to their situation, culture, health status, and level of disability
- Receive accurate and easily understood information about their care plan, health care professionals, and health care facilities
- Participate in decisions about their care and obtain information about treatment options
- Refuse care
- Have their healthcare information be treated confidentially

- Review their client records (including medical records) and request that any inaccurate, irrelevant, or incomplete information be changed as per local policies and procedures.

Clients are responsible for:

- Providing documentation to verify their eligibility for HCP services
- Being involved in their healthcare and adhering to their treatment plan
- Disclosing relevant information
- Clearly communicating their wants and needs
- Treating service providers appropriately and with respect at all times
- Arranging services in a way that avoids emergencies whenever possible
- Maintaining periodic contact with their relevant service provider
- Following provider written policies and procedures and guidelines
- Following written or verbal instructions regarding treatments, activities, safety policies, and utilization of services

Monitoring **Client Rights and Responsibilities** – A copy of the client form outlining Client Rights and Responsibilities must be provided. Review of client acknowledgment will be done via chart reviews.

Staffing Requirements and Qualifications

Education/Experience/Supervision

All staff must hold the appropriate degrees, certification, licenses, permits or other qualifying documentation as required by Federal, State, County, local authorities, or HCP Standards of Care. See each specific service standard for detailed requirements by service.

Monitoring **Staff Education and Experience** - Proof of required staff degrees, certification, licenses, permits, or other qualifying documentation must be available for review during site visits.

Staff Orientation and Training

Initial: All staff providing direct services to clients or making decisions about HIV service 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
- Navigation of the local HIV system of care, including ADAP
- Confidentiality and Security
- Cultural sensitivity, including but not limited to LGBTQ cultural competence, cultural humility, and social determinants of health Other topics may include:
- Psychosocial issues
- Health maintenance for people living with HIV
- Client service expectations

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Confidentiality agreements by staff must be reviewed and re-signed annually.

Training requirements and updated confidentiality agreements must be clearly documented, and completed trainings must be tracked for monitoring purposes.

***Monitoring* Staff Orientation and Training -**

Agencies must maintain a comprehensive list of staff with hire date, all trainings provided, dates of trainings, and dates of refreshed confidentiality agreements; this list must be available for review during site visits or upon request.

Cultural and Linguistic Competency

According to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), culturally and linguistically competent services are those that "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred

languages, health literacy and other communication needs." Providers shall provide services that:

- Treat people living with HIV with respect, and are skilled and culturally-appropriate for the communities served
- Reflect the culture of the community served
- Comply with American Disabilities Act (ADA) criteria
- Are in a location and have hours that make it accessible to the community served
- Are provided in the client's primary language. If that language is not English, interpretation must be provided by a staff member or other means
- Are provided in areas with posted and written materials in appropriate languages for the clients served
- Provide interpreters or access to real-time interpreter services (including phone, Skype, etc.) For HIPPA covered services, interpretation services must follow HIPPA requirements; family and friends should not be used for interpretation. For non-HIPPA covered services, family and friends should only provide interpretation as a last resort and with the prior permission of the client.

Monitoring **Culturally and Linguistic**

Competency - Compliance with CLAS Standards, including ADA criteria and accessible location/hours of services, will be monitored via direct observation of site setup and function during site visits.

Fiscal Responsibility

Payer of Last Resort

Federal legislation states that Ryan White funds are the payer of last resort. This means that no HCP funds can be used for services that could reasonably be paid for or provided by another funding source. Providers are required to screen all clients for eligibility for other programs such as Medi-Cal, Denti-Cal, private insurance (including Covered California plans), Cal-Fresh (SNAP), etc. While there are limitations on when clients can sign up for

Covered California as defined by open enrollment dates, providers should be aware that there are special enrollment periods for certain circumstances (e.g., divorce and loss employment). There are no restrictions when a person can sign up for Medi-Cal or CalFresh as these programs have on-going enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist HCP clients with the process of signing up for those programs.

Ryan White legislation also states that other funding sources must be utilized prior to Ryan White funds being used. However there are times that HCP can pay for services covered by other funding. To pay for services covered by Medi-Cal, Denti-Cal, private insurance or other programs, service providers must provide documentation of the need for additional services beyond what the client's health care coverage or other benefits provide or if an exception was made due to no available provider. Funds cannot be used to pay for services from a provider not in the client's health care provider network, unless the medically necessary service cannot be obtained through an in-network provider.

The Department of Veterans Affairs (VA) – HCP service providers may not deny services, including prescription drugs, to a veteran who is otherwise eligible to receive HCP services. Providers may not cite the "payer of last resort" language to compel a veteran living with HIV to obtain services from the VA health care system or refuse to provide services. However, the VA system differs from other payers because of its unique structure as an integrated care system under which the VA may serve as both payer and provider. The VA is not an insurance or entitlement program. Providers should work with the local VA to ensure clients receive all needed core and support services. HCP can pay for services that are unavailable from the VA. For more information see HRSA Policy Notice 16-01. Indian Health Services (IHS) programs are exempt from the payer of last resort mandate. For more information see HRSA Policy Notice 07-01.

Quality Assurance

Service Evaluation

Each service provider is responsible for evaluating and reporting its performance relative to care standards, and is subject to client chart, utilization, and other types of audits. Service providers must:

- Collect and examine client satisfaction data, and have a process to act on the information reported
- In response to any findings as part of routine HCP monitoring, develop and implement a Corrective Action Plan (CAP)
- Maintain a grievance procedure which provides for the objective review of client grievances and alleged violations of care and service standards ○ Clients must be routinely informed about and assisted in utilizing this procedure

- Clients must not be discriminated against for utilizing the grievance procedure

- Have a client complaint procedure which addresses issues not appropriate to the grievance procedure. Complaints will be investigated and responded to in a timely and respectful manner according to local written policies and procedures. Documentation of investigation and response should be maintained in writing and kept separate from the regular client file

***Monitoring* Quality Assurance –**A copy of the Grievance Policy must be provided to HCP. Oversight of submitted client grievances will occur during site visits. The Grievance Policy may be incorporated into the Client Rights and Responsibility form

Clinical Quality Management - For clinical services, comply with requirements in the California Ryan White Part B Clinical Quality Management Plan

HIPAA Compliance and Non-HIPAA/HITECH Contractors/Providers

- All providers of HIPAA-covered services 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 a client, and with regards to record maintenance.

- All non-HIPAA covered contractors and providers (including tax preparation professionals, accountants, law firms, etc.) must comply with the Information Privacy and Security Requirements set forth in the HCP/MAI contract.
- All contractors and providers must have their employees and volunteers sign the Agreement by Employee/Contractor to Comply with Confidentiality Requirements (CDPH 8689) upon hire prior to having access to any confidential information and on an annual basis thereafter.

Monitoring

Confidentiality Compliance - Signed agreements to comply with confidentiality requirements (CDPH 8689) must made available during site visits.