HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Section 11 – Quality Advisory Committee

SECTION	SECTION / POLICY TITLE	CURRENT VERSION	PREVIOUS REVISIONS
11	**SERVICE STANDARDS**		
	Universal Service Standards	05/25/2022	01/27/21, 08/26/20 06/27/18
	SSC 01 – Medical Case Management Services	06/25/2025	06/22/22, 01/27/21, 12/11/19, 04/25/18, 03/25/15, 04/8/10, 01/26/05, 07/25/01
	SSC 02 – Respite Services	06/22/2022	06/24/20, 06/27/18, 04/27/16, 03/25/15, 07/22/98
	SSC 03 – Dental Services	09/25/2024	06/22/22, 01/27/21, 02/26/20, 06/27/18, 04/27/16, 03/25/15, 06/2/10, 12/10/08, 06/22/05, 06/98
	SSC 04 – Support Services	08/26/2026	06/22/22, 10/27/21, 04/25/18, 04/27/16, 03/25/15, 12/98
	SSC 05 – Eligibility and Fees	03/25/2026	05/25/22, 04/22/20, 06/27/18, 04/27/16, 03/25/15, 01/23/13, 08/24/11, 05/5/10, 12/10/08, 05/24/06, 07/23/03, 01/22/03, 09/27/00
	SSC 06 – Substance Abuse Outpatient Services	06/22/2022	04/22/20, 04/27/16, 12/8/10, 07/23/03, 07/26/00
	SSC 07 – General Policy Directives for Ryan White Part A/B Services	Inactive	09/27/00

	SSC 08 - Child Care Services	09/25/2024	06/22/22, 06/24/20, 04/27/16, 01/26/11, 05/24/06, 07/23/03
	SSC 09 - General Policy Directives for Apportionment of Ryan White Part A/B Funding	Inactive	03/28/01
	SSC 10 – Utilities Assistance Services	Inactive 5/27/2020	04/27/16, 01/26/11, 05/24/06, 07/23/03
	SSC 11 – Medical Transportation Services	01/22/2025	06/22/22, 02/24/21, 4/22/20, 04/27/16, 05/5/10, 7/23/03
	SSC 12 – Food Bank/Home Delivered Meals	12/11/2024	04/22/20, 04/27/16, 12/8/10, 09/27/06, 01/22/03
	SSC 13 – Complementary/Alternative Therapies Services	Inactive - 4/27/2011	01/22/03
	SSC 14 – Mental Health Services	12/11/2024	06/22/22, 01/27/21, 06/24/20, 05/27/20, 07/26/16, 01/26/11, 12/13/06
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HIV Health Services Planning Council
Sacramento TGA

UNIVERSAL SERVICE STANDARDS

Date Approved: 06/26/18
Date Revised: 05/25/22
Date Reviewed: 05/25/22

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

1.0 Intake and Eligibility		
Standard	**Measure**	**Responsibility**
1.1 Clients who qualify and meet eligibility requirements are actively enrolled in Ryan White funded services.	1.1 Documentation in client record or an active referral for service on file.	1.1 Subrecipient
1.2 Agency will conduct a comprehensive intake and eligibility criteria must be verified and documented, including: a. HIV-positive status* b. Resident of Sacramento TGA c. Income not greater than current service caps and limitations (PCN #13-02 person must be low-income to receive RW services) d. Insurance status** *Once HIV status is verified, providers do not need to request HIV documentation during future recertifications. **Although insurance is not a program eligibility requirement, providers must screen all clients as Ryan White is payer of last resort. Providers should document	1.2 Documentation in client record or an active referral for service on file. 1.2.a. **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: o 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 Ryan White-funded services, there is no legislative requirement for a "confirmed" HIV diagnosis prior to care (i.e.*	1.2 Subrecipient

their efforts to enroll clients in comprehensive health care coverage.	*initial HIV screening test results is sufficient, though confirmatory testing should be ordered on first visit. See clarifying letter from HRSA on this issue).* o 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. o 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. 1.2.b. **Residency:** Acceptable residency verification consists of the client's name and address on one of the following: o California driver's license or California Identity Card o 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 o Dated within the last 30-days:	

	• California rent or mortgage receipt • Current utility bill with the service address listed in California (a cell phone bill is not acceptable) • Employment paycheck stub o Dated within one year: • Rental/lease agreement or annual lease renewal documentation • Voter registration card • Vehicle registration (not expired) • W-2 or 1099 (prior tax year documents will be accepted until February 15th. After February 15th, only current tax year documents will be accepted.) • Social Security/Disability Award Letter (SSI, SSDI) • California Employment Development Department (EDD) award letter • Filed State or Federal tax return • Public housing letter on official letterhead from Housing and Urban Development (HUD) or a county agency • Notice of Action from the Department of Health Care Services • Medi-Cal beneficiary letter • School records • Property tax receipt • Unemployment document 1.2.c. **Income:** Clients must provide documentation of all forms of income	

	and meet the income requirements. Ryan White financial eligibility 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: o Pay stubs documenting three current consecutive months of income • Three consecutive months of current paystubs, or • If employed more than one year, one paystub showing Year-To-Date (YTD) earnings that includes at least three months of income, or • If employed less than one year, one paystub showing YTD earnings that includes at least three months of income and lists the employment start date o Private disability award letter (dated within one year) o Supplemental Security Income (SSI) award letter (dated within one year) o Social Security Disability Income (SSDI) award letter (dated within one year) o Bank statement showing direct deposit of Unemployment Insurance, SSI/SSDI benefits. Statement must be dated within one month and clearly identify the deposit/income source (e.g., US Treasury, SSA) o State Disability Insurance (SDI) award letter (dated within one year) o Social Security Retirement Benefit award letter (dated within one year)	

	o Retirement/Pension award letter (dated within one year) o Unemployment Insurance (UI) award letter (dated within one year) o Spousal support court documentation o Worker's Compensation award letter (dated within one year) o Investment income documentation (e.g., statement or portfolio summary dated within one month) o Veteran's Administration Benefits (VA) award letter (dated within one year) o Rental income documentation (e.g., a signed rental agreement dated within the last year or three current bank statements showing rental income deposits) o If self-employed, provide ADAP Self-Employment Affidavit form – CDPH 8726. o 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. 1.2.d. **Insurance:** Clients seeking any services through Ryan White-funded programs must provide documentation of health insurance status. Acceptable verification includes one of the following: o Copy of current insurance card, including Medi-Cal Beneficiary Identification Card (BIC) if applicable o Dated screenshots of client insurance status verification using an official insurance screening system o Denial letter from Medi-Cal o 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	
1.3 Agency will notify clients, related agencies, and Recipient of current services, caps, and eligibility restrictions.	1.3 Procedure to ensure distribution of completed Service Matrix or equivalent to clients, related agencies and Recipient in place.	1.3 Subrecipient
1.4 Agency will ensure documentation of client demographic information including unique identifier, name, DOB, SSN, race, ethnicity, gender, mode of transmission, HIV status, current address, income, insurance sources, and evidence of care as defined by Recipient.	1.4 Documentation of client level data will be found in each client file.	1.4 Subrecipient
1.5 Agency will ensure client signs and receives copies of the Client's Rights and Responsibilities, ARIES Share Form, Release of Information, Grievance Procedure and other required program documentation.	1.5 Documentation in client file.	1.5 Subrecipient

2.0 Key Services Components and Activities		
Standard	**Measure**	**Responsibility**
2.1 Agency has a Drug-Free Workplace policy.	2.1 Written drug-free workplace policy on file.	2.1 Subrecipient
2.2 Agency has a policy of non-discrimination in regards to hiring and service delivery.	2.2 Written non-discrimination policy on file.	2.2 Subrecipient
2.3 Agency has a process in place for the recapture of funds when other payer sources are identified or client eligibility has changed.	2.4 Written policy on file.	2.3 Subrecipient
2.4 Subrecipient has policy for regularly scheduled performance evaluations.	2.4 Documentation of evaluations on file.	2.4 Subrecipient

2.5 Agency will have a procedure to make linkages to other Ryan White services or other community services.	2.5 Description of process and examples of referrals made.	2.5 Subrecipient
2.6 Agency will notify clients of current services, caps, and eligibility restrictions.	2.6 Procedure to ensure distribution of completed Service Matrix or equivalent to clients.	2.6 Subrecipient
2.7 Agency will notify clients of any recipient approved changes to current program benefits prior to implementation**.**	2.7 Communicate changes sent to clients regarding program benefits will be on file.	2.7 Subrecipient
2.8 Agency will ensure appropriate staff receives initial training and ongoing education regarding the use of the SHARE database.	2.8 Proof of User IT Agreements; Client intake manual available at worksite.	2.8 Subrecipient
2.9 Appointments must be offered no later than 10 calendar days from the first client referral.	2.9 Written policy on file.	2.9 Subrecipient

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

4.0 Assessment and Service Plan		
Standard	**Measure**	**Responsibility**
4.1 Within 30 days of initial client contact, clients will be assessed using an acuity scale.	4.1 Documentation in client file.	4.2 Subrecipient

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

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

6.0 Client Rights and Responsibilities		
Standard	**Measure**	**Responsibility**
6.1 Agency has written policies outlining Client Rights and Responsibilities.	6.1 Documentation of Clients Rights & Responsibilities Policy signed by client.	6.1 Subrecipient

6.2 Agency will accommodate special needs clients as specified by the Americans with Disabilities Act guidelines. www.ada.gov.	6.2 Agency will provide documentation of any requests made and how request was accommodated.	6.2 Subrecipient
7.0 Grievance Process		
Standard	**Measure**	**Responsibility**
7.1 Sub-recipient Policy and Procedure for grievances.	7.1 Agency Written Policy and Procedure.	7.1 Subrecipient
7.2 Grievance Procedure visibly posted in client areas.	7.2 Posted Grievance Procedure.	7.2 Subrecipient
7.3 Client Signs Acknowledgment of Grievance Process.	7.3 Documentation in client file signed by client.	7.3 Subrecipient
8.0 Cultural and Linguistic Competency		
Standard	**Measure**	**Responsibility**
8.1 Staff providing direct services to clients shall receive training and education to build cultural competence.	8.1 Documentation of trainings completed and/or educational materials reviewed on an annual basis.	8.1 Subrecipient
8.2 Clients with language barriers will have access to language appropriate resources and services.	8.2 Staff will have resources available in the primary language used by their clients or will have a contact list for obtaining linguistically appropriate resources and services for their clients.	8.2 Subrecipient

9.0 Privacy and Confidentiality (*including securing records)*		
Standard	**Measure**	**Responsibility**
9.1.a. Agency will develop, implement, maintain and use, at its own expense, such appropriate administrative, technical and physical safeguards as may be required to protect client confidentiality. 1. Confidentiality policy exists. 2. Data privacy practices such as encryption, passwords, screen savers, shared network drives or other mechanisms will be used. 3. Client records will be stored in a secure and confidential location.	9.1a. 1. Written policy on file. 2. Written policy on file. 3. All records will be double lock protected with access limited to appropriate personnel.	9.1. Subrecipient
9.1.b. Maintain compliance with HIPAA and or HIV Confidentiality Laws, preserve integrity and confidentiality, and prevent disclosure of personal health information. A release of information will be signed by the client prior to exchange information with other providers.	9.1.b. Written HIPAA policy and standardized release form(s) on file.	9.1.b. Subrecipient
9.2 Agency will provide a confidential meeting space.	9.2 Review of confidential space.	9.2 Recipient/ Subrecipient
9.3 Agency will ensure client there is a valid Release of Information on file for each client.	9.3 Documentation in client file signed by client.	9.3 Subrecipient

10.0 Recertification Requirements		
Standard	**Measure**	**Responsibility**
10.1 Eligibility must be determined at initial enrollment and certified at the client's birthdate and every year thereafter to align recertification with the AIDS Drug Assistance Program.	10.1 Documentation in client file.	10.1 Subrecipient

This change may require two eligibility determinations within the client's first year of service as indicated below:

Client Birthdate	Initial Enrollment Date	First Recertification Occurs
January 15	April 15, 2022	January 15, 2023
April 15		April 15, 2023
July 15		July 15, 2023
October 15		October 15, 2023

Subsequent recertification would occur every 12 months thereafter on the client's birthdate.

10.2 Subrecipients should adopt practices to periodically check for changes in client's income and residency throughout the year.	10.2 Documentation in client file.	10.2 Subrecipient

11.0 Fiscal Responsibility		
Standard	**Measure**	**Responsibility**
11.1 Providers must make reasonable efforts to secure non-Ryan White HIV/AIDS Program funds whenever possible for services to eligible clients (i.e., Ryan White must be the "payer of last resort").	11.1 Documentation in client file.	11.1 Subrecipient
11.2 Ryan White funds are intended to support only the HIV-related needs of eligible individuals. An explicit connection must be made between any service supported with Ryan White funds and the intended client's HIV status.	11.2 Documentation in client file.	11.2 Subrecipient
11.3 Ryan White funds may not be used to make cash payments to intended clients of Ryan White-funded services. This prohibition includes cash incentives and cash intended as payment for Ryan White core medical and support services. Other unallowable costs include: • Clothing • Employment and Employment-Readiness Services, • Funeral and Burial Expenses • Property Taxes • Pre-Exposure Prophylaxis (PrEP) • Non-occupational Post-Exposure Prophylaxis (nPEP) • Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual • International travel • Travel outside of California • The purchase or improvement of land • The purchase, construction, or permanent improvement of any	11.3 Documentation in client file.	11.3 Subrecipient

building or other facility		
11.4 Documentation of Need. Documentation of need is required 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 Ryan White as the payer of last resort.	11.4 Documentation in client file. Client charts must include the following: o A description of the need for additional medically necessary services, beyond what the client's health care coverage or other benefits provide o 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 Ryan White funds cannot be used to pay for services provided by a provider not in the client's health careprovider network, unless the medically necessary service cannot be obtained through an in-network provider.* **Reminder:** All Ryan White-funded 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.	11.4 Subrecipient
11.5 Payer of Last Resort: Federal legislation states that Ryan White funds are the payer of last resort. This means that no Ryan White 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	11.5 Documentation in client file.	11.5 Subrecipient

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 Cal-Fresh as these programs have on-going enrollment. Providing benefits counseling to clients must involve working with eligibility workers from other programs to assist Ryan White 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 Ryan White funds 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 currently available appointment with a 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. Ryan White funds cannot pay for appointments missed by a client. All providers of Ryan White services who are providing any the following services must be Medi-Cal / Denti-Cal providers (with exceptions outlined under Oral Health service standard section): Outpatient Ambulatory Health Services, Oral Health, Mental Health, Substance Abuse Outpatient Services, Substance Abuse Services (Residential).		

The Department of Veterans Affairs (VA) Ryan White-funded service providers may not deny services, including prescription drugs, to a veteran who is otherwise eligible to receive Ryan White-funded 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. 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. Ryan White funds 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.		

Adopted: _____ Date: 05/25/22

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Parts A and B
Policy and Procedure Manual

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

No.: SSC 01
Date Adopted: 07/25/2001
Last Reviewed:06/25/2025
Date Approved:06/25/2025

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

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

PURPOSE OF MEDICAL CASE MANAGEMENT

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

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

Required Care Objectives include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a medical case manager

- Initial assessment of the client's service needs within 30 days of the first visit
- Development of a comprehensive, individualized care plan at the initial assessment, including client-centered goals and milestones
- Timely and coordinated access to medically appropriate levels of healthcare and support services based on clinical and acuity status of the client
- Routine client monitoring to determine the efficacy of the care plan
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support system
- Treatment adherence counseling to ensure that the client is ready for and adheres to HIV treatments
- Client-specific advocacy and/or review of service utilization as appropriate; and,
- Benefits counseling whereby staff assist eligible clients in obtaining access to other public and private programs for which they may be eligible including but not limited to; Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (HIPP), Disability Insurance, Social Security, pharmaceutical manufacturers' patient assistance programs, Covered California, Housing Opportunities for Persons with AIDS (HOPWA), and/or other state or local health care and supportive services.

PRINCIPLES OF MEDICAL CASE MANAGEMENT

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

- Participatory in that the medical case manager will engage the client in informed decision making to establish a client-optimized individual plan of care.

- Empowering clients in developing constructive lifestyles and life choices that will facilitate routine medical care by eliminating barriers to care or other factors that impede optimal function of the client.

- Goal-oriented in the development of the client care plan in order to assess progress and effectiveness of medical case management.

- Flexible in response to the client's immediate, emerging, or otherwise changing needs.

- Culturally proficient in terms and contexts that are understandable and account for the client's personal situation/environment.

- Efficient in design for the purpose of optimizing client specific services based upon need.

- Cost-effective by facilitating the use of resources that will effectively prevent the client from having to access more expensive alternatives.

- Accessible through planned multiple access regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.

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

FUNCTIONS OF MEDICAL CASE MANAGEMENT

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

Required objectives:

- Offer accurate and current information to the client

- Assist the client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions

- Present options to the client from which he/she may select a course of action

- Offer opinion and direction when it is asked for, or when to withhold it would place the client or someone else at risk for harm

- Be available to support and problem solve and to not judge the client in the present or future based upon their decision(s) of the past

- Gather and evaluate information from the client

- In participation with the client, create a care plan that addresses basic living needs, medical treatment and compliance issues, and other

appropriate social service needs

- Promote, coordinate and collaborative communication between clients and all persons involved in the client's care

- Educate the client on available resources and assist them in accessing those resources

- Reinforce treatment adherence counseling to ensure readiness for the complex HIV/AIDS regiments, coordination of service and monitoring plan

EDUCATION REQUIREMENTS FOR DESIGNATIONAS MEDICAL CASE MANAGER

Minimum Qualifications

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

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

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

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

Monitoring

Education/Experience/Supervision - Credentialing and/or other education or experience meeting the minimum requirements for service provision in this category must be kept in personnel files, with hire date. Availability of clinical supervision for unlicensed medical case managers will be monitored via discussion during site visits.

Training

Initial: All staff designated as a Medical Case Manager and those staff providing affiliate case management services must complete an initial

training session specific to providing and coordinating service to HIV afflicted individuals. Training is to be completed within 60 days of hire covering at minimum the following topics:

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

The above required training does not preclude a contracted HIV Care Services Program subrecipient from determining or otherwise administering additional employer-based training to the provider's work force as appropriate and necessary or attendance at ongoing Medical Case Management training opportunities organized by the Recipient.

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) Articles, (3) home studies, or (4) webinar.

Monitoring

Staff Training- All trainings provided, and dates of trainings must be available for review during site visits or upon request.

MEDICAL CASE MANAGEMENT PROCESS

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

Process standards are identified and addressed in the following areas:

- Intake
- Assessment
- Reassessment

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

Intake

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

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

Required intake activity processes are outlined below:

- the HIV Care Services Program Intake form will be completed in its entirety

- the client will be assessed with an Acuity scale which will be dated and signed by the medical case manager. The acuity scale will be updated every six months for medical case management clients

- the client's Informed Consent to Participate in the medical case management program shall be obtained

- the client will be informed of their right to confidentiality and information privacy procedures

- the client will be informed of the Release of Information Form, and will be asked to provide consent to the appropriate release of information to other pertinent entities

- release of information form must be updated annually.

- the client will be informed of, and agree to the Client's Rights and Responsibilities form

- the client will be informed of the agencies' as well as the Ryan White Program's Grievance Procedure
- the client will be informed of the role and purpose of medical case management
- anticipating basic eligibility, the client may proceed to formal assessment, or be referred to another case management agency (if the client would be better served based upon their particular need for medical or non-medical case management services)
- create a client file and archive all relevant documents and forms

Eligibility

Eligibility requirements for Ryan White services can be found in SSC 05 – Eligibility and Fees for Ryan White Part A/B Services. Clients who are receiving Targeted Case Management through the county (a Medi-Cal services) are still eligible for Non-Medical Case Management from the Ryan White Program as the Targeted Case Management services do not meet the minimum standards of Non-Medical Case Management as defined in this standard. It is recommended that the Ryan White funded case manager coordinate services with the Targeted Case Management case manager to avoid duplication of efforts and confusion for the client.

Assessment

Required assessment process and criteria:

- initial Medical Case Management face-to-face appointments must occur no later than 10 calendar days from the date of referral
- service agency must have in place a process to ensure timely follow-up of no-show clients preferably within 24-hours
- any client ineligible for Medical Case Management must be referred to an appropriate alternate support service through a warm hand off process
- the Medical Case Manager must complete an in-person psychosocial needs assessment within 30 days of the start of Medical Case Management

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

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

Assessment content should address:

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

- Nutritional status assessment
- Partner Services needs
- Cultural issues, including ethnic, spiritual, etc. and,
- Summary of unmet needs.

Monitoring

Initial Assessment - Performance of a timely initial assessment, along with complete documentation of assessment findings and applicable referrals/linkages, will be monitored via site visit chart review.

CARE PLAN DEVELOPMENT AND IMPLEMENTATION

Required process and components of care plan formulation:

- development is based on an approved acuity scale
- includes any CD4 count and/or viral load tests during the measurement year
- all medical provider visits will be documented as part of the care plan progress note and those visits client self-reported will be verified by the medical case manager inclusive of date through direct contact with the provider, transcript of case conference notes or other corroborating documentation as appropriate.
- individualized holistic with emphasis on medical needs
- includes realistic, measurable goals that are time framed and consistent with ongoing inter-professional assessment
- intervention responsibility is identified be it provider, vendor, facility or service
- is participatory with the client and reflects client concurrence with initial plan and all updates thereafter
- multiagency or inter-professional collaboration is identified and coordinated
- care plan is documented in an approved format that can be of varying

medium i.e., paper chart, EMR, HIV Care Connect (HCC) etc.

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

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

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

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

Monitoring

Care Plans - Development of individualized, medically-focused care plans that meet the requirements laid out above will be monitored via review of client charts and/or electronic health records during site visits.

- Case conferencing required components

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

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

    - for clients experiencing significant changes or unexpected absence from care, more frequent case conferences may be necessary

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

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

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

- Treatment adherence counseling requirements

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

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

  - refer clients to additional treatment adherence services as needed

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

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

  - monitor laboratory values as appropriate

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

QUALITY ASSURANCE AND SUPERVISION

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

Required Standards:

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

CASELOAD

Depending on the acuity of clients, as a guideline, Medical Case Managers are encouraged to maintain a caseload of between 40 and 65 clients per 1.0 full time employee (FTE) . Prior to creating a wait list, clients should be referred to another Medical Case Management subrecipient.

Monitoring

Caseload – Agencies must submit their written policies and procedures for caseload review and redistribution when warranted, to adhere to caseload standards.

DOCUMENTATION STANDARDS

Client Record:

- all Medical Case Management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record within 48 hours and entered into the State Part B database, HIV Care Connect, within two (2) weeks as appropriate.

- all documentation of activities must be legible, signed, and dated by the Medical Case Manager or authenticated in an electronic manner consistent with an electronic health record or other record system

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

Monitor Treatment Adherence: Medical Case Managers shall monitor client treatment adherence. Client self-report, pill counts, electronic pill bottle caps, diaries, adherence watches and other reminder systems, lab reports, etc. are used to assist with adherence monitoring. Lab reports, particularly viral suppression status, are an integral part of understanding a client's adherence to medications and medical care. The Medical Case Manager must determine which method(s) may be helpful for a particular client. As needed, the Medical Case Manager shall determine who has the primary responsibility for giving medication and shall provide HIV and adherence education to family members or caregivers as applicable. Medical Case Managers shall refer clients to additional treatment adherence services as needed.

To support treatment adherence, Medical Case Managers shall:

- Identify barriers to adherence in each case (housing instability, alcohol and drug use, mental health issues, financial factors, attitudes toward medicines, etc.)
- Communicate any adherence barriers to the client's medical care providers and work to address the barriers, updating the care plan as needed.
- Consult the client's current laboratory results regularly for monitoring purposes

Advocacy and Utilization Review

Medical Case Managers must ensure the provision of a basic needs assessment and assistance (through appropriate referrals) in obtaining medical, social, community, legal, financial, and other needed services.

Key activities include:

- Assessment of service needs
- Provision of information and/or referrals; referrals should involve a warm handoff whenever possible
- Assistance in obtaining an official identity document (ID) such as a California ID card, if needed

TRANSFER AND DISCHARGE

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

Conditions for appropriate transfer, discharge or case closure include:

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

Standards for client transfer, discharge or closure include:

- matters related to transfer, discharge or closure are discussed through in-person interaction with the client or client's representative

- circumstances necessitating service termination outside of routine transfer, discharge or closure require consultation and concurrence with appropriate agency management

- involuntary termination of service requires implementation of an established agency protocol that minimally includes the following components

    - client notification process and complete with timelines
    - notice of appeals process
    - exploration of alternative care that is coordinated with the receiving service
    - process for intermittent suspension of service

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

GRIEVANCE PROCESS

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

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

Approved: _____ Date: 06/25/2025

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Respite Service Standards

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

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

HRSA Definition:
Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HRSA RWHAP-eligible client to relieve the primary caregiver responsible for their day-today care.

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

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

3. In accordance with the above:

Objective

Respite Services are intended to maintain/improve a client's ability to maintain or access medical care.

Education/Experience/Supervision There are no minimum educational standards for staff providing Respite care reimbursement services.

Individual supervision and guidance must be available to all staff as needed.

Staff Orientation and Training

Initial: All staff providing Respite Reimbursement Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

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

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar, and must be clearly documented and tracked for monitoring purposes.

Intake

The Respite Service providers must ensure that the client intake has been performed prior to Ryan White service provision and if not, perform an intake. See the Universal Standards for detailed intake requirements. Providers should ensure that any consents specific to childcare services are completed and in the client's file.

Orientation

Each new client receiving respite services must receive an orientation to provided services; document this orientation in the client file.

Reassessment

The client's care plan must be updated at least every six months.

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

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

A. Criteria

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

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

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

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

B. Qualifications

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

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

C. Amount of Service

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

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

5. RW Agencies which provide Respite Services shall develop and adhere to

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

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

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

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

Signed: _____ Date: 06/22/22

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Oral Health

No.: SSC03
Date Approved: 06/98
Date Revised: 9/25/2024
Date Reviewed: 9/25/2024

Consistent with the United States Health Resources Services Administration's (HRSA), Policy Clarification Notice 16-02 and as directed by the HIV Health Services Planning Council established priorities, when funded, the following service standards will apply to HIV Care Services Program contracted subrecipients.

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

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

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the patient before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

   - CD4 **or** Viral Loads within the past 12 months
   - Release of information,
   - Grievance,
   - Rights and responsibilities,

- State ARIES/HIV Care Connect (HCC) forms, etc.

All oral health care services, either in-house or specialty referral, are capped at $1,800 per person, annually. (Refer to Fiscal Requirements, Page 6)

Reimbursement for services can only be paid for active patients meeting eligibility.

4. The United States Health Resources Services Administration (HRSA) defines Oral Health Care as outpatient diagnostic, preventive, and/or therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

In accordance with the HRSA HIV Performance Measures and with the above:

A. Ryan White-funded Oral Health services must conform to the most current Medi-Cal Dental Program Provider Handbook including the Manual of Criteria & Maximum Allowances, as distributed by the Sacramento County Public Health, Sexual Health Promotion Unit, HIV Care Services Program.

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

- Service that is determined medically necessary, including diagnostic screenings, shall be paid for with Ryan White funds, as defined by the most current Medi-Cal Dental Program Provider Handbook including the Manual of Criteria & Maximum Allowances.
- Medical history taking
- Comprehensive oral exam
- A documented dental treatment plan including a referral system for urgent care matters and/or services needed by patients but not fundable through Ryan White.
- Diagnostic dental care
- Preventative dental care
- Therapeutic dental care
- Documentation of oral health education
- Coordination of care with primary care provider and other services
- Documented provision of any oral examination during the measurement year (March- February for Part A) (April-March for Part B)
- Documentation of initial and updated health history including:

a. Current medications
b. Appropriate lab values
c. Name of primary medical care provider
d. Review of substance use (smoking/tobacco, alcohol, and drug use)

- Documentation of progress, review, and outcome of the dental treatment plan

Monitoring

Service- Develop scopes of work for the provision of oral health that:

- Specify allowable diagnostic, preventive, and therapeutic services.
- Define and specify the limitations or caps on providing oral health services.
- Ensure that services are provided by dental professionals certified and licensed according to state guidelines.
- Ensure that clinical decisions are informed by the American Dental Association Dental Practice Parameters.

C. Service Characteristics

Initial Oral Health Care Appointments: Initial Oral Health Care appointments should be made as soon as possible to avoid potential dropout. Emergency or urgent appointments should be provided as soon as possible, on the same day if feasible. Initial non-urgent appointments must occur no later than 90 calendar days after the first patient referral to a Ryan White oral health provider.

Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after request to minimize the need for urgent or emergency services.

As patients may miss appointments, agencies must have a process in place to ensure timely follow-up with patients. Missed appointments and subrecipient attempts at rescheduling must be documented in the file.

Monitoring

Appointment Times - Procedures for ensuring the first appointment for new patients is offered within 90 days, as well as urgent/emergent appointments and subsequent non-urgent appointments, will be reviewed through submission of agency written procedures. Agencies will be asked to submit to the Ryan White Program, written procedures for client follow-up after missed appointments.

Eligibility Screening and Intake

The Oral Health Care subrecipients must ensure that the patient has been deemed eligible for Ryan White-funded services by the referring agency; subrecipients should verify that intake has been performed at the start of service provision and if not, perform an intake. Subrecipients should ensure that any consents and Releases of Information specific to dental care are completed and in the patient's file; subrecipients must take the necessary steps to obtain these forms if missing.

Initial Assessment

At the start of Oral Health Care Services, a baseline dental evaluation must be conducted. This evaluation should include, at a minimum:

- **Medical history.** The subrecipient shall perform a complete medical history for every new patient. This should include:
  - Patient's chief complaint
  - HIV medical care provider
  - Current medication regimen(s) and adherence, including HIV medications
  - Alcohol, drug, and tobacco use
  - Allergies
  - Usual oral hygiene
  - Date of last dental examination, and name of last dentist if known

- **Oral examination.** Each patient should be given a comprehensive oral examination and assessment. This examination should include:
  - Documentation of the patient's presenting complaint
  - Medical and dental history
  - Caries (cavities) charting
  - X-rays: Full mouth radiographs or panoramic and bitewing x-rays
  - Complete oral hygiene and periodontal exam
  - Comprehensive head and neck exam
  - Complete intra-oral exam, including evaluation for HIV-associated lesions or STIs
  - Soft tissue exam for cancer screening
  - Pain assessment
  - Risk factors

Patient Education: Patients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency. See the *Preventative Care and Maintenance* section of this document for more details.

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

Patient Treatment Plan
Oral Health Care subrecipients should create an individualized dental treatment plan for each patient. The plan should:

- Identify and prioritize the patient's dental care needs
- Incorporate patient input
- Describe the proposed interventions and treatment schedule
- Include any referrals and linkages to specialty care or other needed services
- Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed with patient input.

Preventative Care and Maintenance
Oral Health Care subrecipients should emphasize prevention, early detection of oral disease, and preventive oral health practices. Education shall include:

- Instruction on oral hygiene, including proper brushing, flossing, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- Effects of poor oral health on overall health
- The effect of nutrition on oral health.

NOTE: Toothbrushes, toothpaste, dental floss, and mouth rinses may be purchased under the Food Bank/Home-Delivered Meals service category.

In addition, patients should be scheduled for routine dental health maintenance visits, as follows:

- Routine examinations and prophylaxis up to twice a year
- Comprehensive cleaning up to twice a year, preferably twice a year
- Other procedures, as determined medically necessary by using criteria listed in the most current Medi-Cal Dental Program Provider Handbook and as stated in the Manual of Criteria & Maximum Allowances.

Patient Referral / Linkage: Patients requiring specialized care should be referred for and linked to such care via the patient's case manager

and/or HIV care team, with documentation of that referral in the patient file and available upon request.

A referral to specialty care does not guarantee coverage by the HIV Care Services Program.

Fiscal Requirements

- Subrecipient will make every reasonable attempt to provide patients with a referral to local, free, or low-cost non-Ryan White related grant, community partner, or other service that may be available to the patient to access the service not provided by Ryan White Provider.
- The current Medi-Cal Dental Program's Manual of Criteria is followed when determining which services will be covered by the Sacramento TGA Ryan White HIV Care Services program.
- The current Medi-Cal Dental Schedule of Maximum Allowances is followed when determining the fee coverage maximum covered by the Sacramento TGA HIV Care Services program.
- No Medi-Cal Dental provider is located within 30 minutes or 15 miles of a patient's residence or workplace. (Medi-Cal Dental Provider Search)
- No Medi-Cal Dental provider is accepting new patients within 30 minutes or 15 miles of a patient's residence or workplace.
- A Medi-Cal Dental eligible patient who is having an oral health emergency and cannot get an appointment with a Medi-Cal Dental provider.
- The total cost for services per patient is capped at $1,800 annually, regardless of HIV Care Services funding stream.
    - Uninsured/Under-insured: $1,800 annual cap regardless of HIV Care Services Program funding stream.
    - Medi-Cal: Medi-Cal cap only
    - Private Insurance: Private Insurance cap only

  To exceed this cap, a request for approval must be submitted to the Recipient. Dental providers must document the reason for exceeding the yearly maximum amount and must have documented approval from the Recipient.

Subrecipients must show adequate documentation of the above-mentioned exceptions. In these situations, the subrecipient will submit a usual and customary reduced negotiated rate to the Recipient with a Treatment Authorization Referral (TAR), prior to services being rendered for approval for utilization of Ryan White funding.

Subrecipients cannot bill the HIV Care Services program for services billed, or eligible billable services, to the Medi-Cal Dental Program.

Subrecipients are not required to enter into a contract with a Medi-Cal Dental fee-for-service dentist if the proposed dentist is using the Medi-Cal Dental Manual of Criteria & Maximum Allowances. It is up to the subrecipient to ensure the dentist agrees to fee amounts set by the HIV Services Planning Council Subrecipients are required to enter into a subcontract/MOU with any Medi-Cal Dental fee-for service dentist or any dental provider not using the Medi-Cal Dental Manual of Criteria and Maximum Allowances. Subcontracts/MOUs must be reviewed and approved by the Recipient prior to execution.

Monitoring

Fiscal Requirements - In cases where patients are eligible for Medi-Cal Dental Program but no Medi-Cal Dental Program providers are available (i.e. the "time/distance exception" referenced above), providers must submit documentation to the Recipient that clearly demonstrates the absence of providers in this time/distance range per a recent review of Medi-Cal Dental Program providers listed on the DHCS website.

In El Dorado, Placer, and Yolo counties, when no Medi-Cal Dental Provider is available, the subrecipient will negotiate the best rate and request approval by the Recipient.

5. **Provider / Staff Qualifications**
Education / Experience / Supervision
Professional diagnostic and therapeutic services under this service category must be provided by clinicians licensed by the Dental Board of California. Clinicians can include:

- General Dentists
- Endodontists
- Oral and Maxillofacial Surgeons
- Periodontists

Other professional and non-professional staff may provide services appropriate for their level of training/education, under the supervision of a clinician. These may include, but are not limited to:

- Dental Hygienists (RDH)
- Dental Assistants (RDA, RDAEF)
- Dental Students

- Dental Hygiene Students
- Dental Assistant Students

Any non-clinician staff providing services must be (1) supervised by a clinician; (2) hold current licensure as required by the State of California when applicable; (3) provide services appropriate for their level of training/education; and (4) be trained and knowledgeable about HIV.

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

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

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

Provider/Staff Orientation and Training

Initial: All RW-funded staff providing Oral Health Care 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 HIV transmission, care, and prevention.
- Diagnosis and assessment of HIV-related oral health issues
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including access to dental insurance through ADAP

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

6. In an effort to overcome any barriers to access and utilization, all Dental services shall be provided in a culturally and/or linguistically competent manner, which is respectful to the patient's cultural health beliefs, practices, and preferred language.

7. Subrecipients shall ensure that no patient receives any RW funded services unless such patient is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

8. Providers/Staff at subrecipient agencies may at any time submit to the Recipient requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique medical/dental needs of a patient or on unique barriers to accessing medical/dental care which may be experienced by a patient.

9. Subrecipients shall provide a means by which providers/staff can obtain in-servicing and on-call advice related to interpreting patient medical/dental needs.

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

Signed: _____ Date: 9/25/2025

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Support Services

No: SSC 04
Date Adopted: 12/98
Date Reviewed: 08/26/26
Date Approved: 08/26/26

As directed by the Sacramento HIV Health Services Planning Council (herein after referred to as the Council) established priorities, when funded, the following service standards will apply to HIV Care Services (HCS) Program contracted service providers.

Policy: The Support Services standards which follow, will be applied uniformly by any contract agency, which receives HCS funding for the various support services listed in the provision of services to HIV+ persons seeking assistance. These standards are to be coordinated with other service standards, as needed, and in conjunction with the Sacramento TGA's Universal Standards and HRSA's Policy Clarification Notice 16-02, which defines and provides program guidance for each of the Support Services and defines individuals who are eligible to receive HCS-funded services. The standards are to be implemented in the context of the approved Case Management Model.

The support service categories are:

Service Category	Service Standard #
• Case management (non-medical)	21
• Child Care services	08
• Emergency financial assistance (Other Critical Need)	16
• Food bank/home-delivered meals	12
• Health Education/Risk Reduction services	20
• Housing	15
• Linguistics services (interpretation and translation)	26
• Medical Transportation	11
• Other professional services (including Legal Services and Permanency Planning)	27
• Outreach services	19
• Psychosocial support services*	17
• Referral for health care/supportive services*	--
• Rehabilitation services*	--
• Respite care*	02

- Substance abuse services – residential* 23

  *Not a funded service at this time

Procedure:

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

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

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

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

   e HCS funds may <u>not</u> be used to fund the following:
      - Pet foods or maintenance products/care
      - Local or state personal property taxes
      - Employment, vocational rehabilitation or employment readiness services
      - Clothing
      - Social outings
      - Funeral and burial expenses
      - Pre-Exposure Prophylaxis (PrEP)
      - non-occupational Post-Exposure Prophylaxis (nPEP)
      - Materials, designed to promote or encourage, directly, intravenous drug use or sexual activity
      - International travel
      - The purchase or improvement of land

- The purchase, construction, or permanent improvement of any building or other facility

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

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

   b Emergencies may be defined around the following specific support service categories only: housing, food, transportation and medication assistance. Other one-time needs are defined as exceptions.

   c Exceptions and emergencies must be documented in the case record and signed by an agency's authorizing person.

   d All exceptions must be time limited.

Signed: _____ Date: 8/26/26
Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Eligibility & Fees for HIV Care Services (HCS) Program funded by the Ryan White CARE Act Part A and Part B Services

No.: SSC 05
Date Adopted: 07/23/03
Date Reviewed: 03/25/26
Date Approved: 03/25/26

As directed by the HIV Health Services Planning Council (herein after referred to as the Council) established priorities, when funded, the following service standards will apply to HCS contracted service providers.

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

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

3. In accordance with the above:

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

B. Eligible Persons will have a case file maintained by a HCS service provider.

Rapid Eligibility Determinations: Eligibility determinations may be performed simultaneously with testing and treatment. Recipients and subrecipients assume the risk of recouping any HCS funds utilized for clients ultimately determined to be ineligible, and instead charge an alternate payment source, or otherwise ensure that funds are returned to the HCS program. In order to document eligibility for HCS services, individual case files must contain mandatory eligibility documentation including:

Proof of HIV-positive status: At the first certification, clients must provide proof of HIV-positive status. (Once HIV status is verified, providers do not need to request HIV documentation during future recertifications.) 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 HCS-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.

- California Department of Public Health Diagnosis Form (CDPH Form 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 HCS-funded 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.

Income: Clients must provide documentation of all forms of income and meet the income requirements. HCS 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 600 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.

Insurance Status: Clients seeking any services through HCS-funded 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

Although insurance is not a program eligibility requirement, providers must screen all clients, as HCS is payer of last resort. Providers should document their efforts to enroll clients in comprehensive health care coverage.

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 HCS 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 HCS 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 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 Ryan White-funded 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, medical 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.

Eligibility must be determined at initial enrollment and certified at the client's birthdate and every year thereafter align recertification with the AIDS Drug Assistance Program. This change may require two eligibility determinations within the client's first year of service as indicated below:

Client Birthdate	Initial Enrollment Date	First Recertification	Annual Recertification
January 15	April 15, 2026	January 15, 2027	Every 12 months thereafter on birthdate
April 15		April 15, 2027	
July 15		July 15, 2027	
October 15		October 15, 2027	

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.

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.

- **HIV Care Connect (HCC)Consent (if applicable):** Providers must obtain a completed HIV Care Connect (HCC) Consent Form for each client. Clients must indicate whether they want to share their HCC data with other HCC-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.

- **Release of Information:** 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.

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

Notifications
As a part of HCS-funded 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 HCS-funded 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 HCS-funded 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.

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

- **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.

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

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

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

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

   i. 5% annual cap for patients with incomes between 100% and 200% of the FPL
   ii. 7% annual cap for patients with incomes between 200% and 300% of the FPL
   iii. 10% annual cap for patients with incomes between 300% and 600% of FPL

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

The Federal Poverty Guidelines can be found in the United States Federal Register at https://www.federalregister.gov and typing Poverty Guidelines and the year in the search field. Example "Poverty Guidelines 2026".

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

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

4. 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, MS Teams, 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.

5. Providers at HCS-funded Agencies may request Recipient interpretation, at any time, of these or any other Services Standards adopted by the Council.

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

Adopted: _____ Date: 03/25/26

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Substance Abuse Treatment Services – Outpatient **No.:** SSC 06

Date Approved: 07/26/00
Date Revised: 06/22/22
Date Reviewed: 06/22/22

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

NOTE: *For clarity and consistency, the service category referenced throughout this document is Substance Abuse Outpatient Care, per PCN #16-02. However, in all other cases, the TGA utilizes 2016 White House Office on National Drug Control Policy (ONDCP) language, including "substance use disorder" instead of "substance abuse."*

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

1. The provision of Substance Abuse Treatment Services - Outpatient shall be consistent with Service Standards 05 (SSC05) Eligibility & Fees for Ryan White Part A and Part B Services and consistent with the Substance Abuse Treatment Services program as outlined herein:

2. Clients presenting through self-referral will be accepted and authorized for Substance Abuse Treatment Services - Outpatient through Ryan White funding only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

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

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

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

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

      i. HIV related medical issues must always take precedent over substance abuse treatment program protocol.
      ii. Any therapeutic treatment model must be tailored for those clients with extreme HIV related medical issues (as determined by a medical provider) not suitable for social model intervention.

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

      Substance Abuse Outpatient Treatment is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

      - Screening
      - Assessment
      - Diagnosis and/or treatment of substance use disorder, including:
        - Pretreatment/recovery readiness programs
        - Harm reduction
        - Behavioral health counseling associated with substance use disorder
        - Outpatient drug-free treatment and counseling
        - Medication assisted therapy
        - Neuro-psychiatric pharmaceuticals
        - Relapse prevention

      Key activities of Substance Abuse Outpatient Care include:

      - Initial assessment of the client's service needs;
      - Recovery readiness determination and relapse prevention strategies;
      - Harm reduction including syringe access;

- Development of a comprehensive, individualized treatment plan including client driven goals and milestones;
- Treatment provision, such as:
  - Behavioral health counseling in individual, family, and/or group settings
  - Crisis intervention
  - Medication-assisted therapy, including the use of disulfiram, acamprosate, naltrexone, methadone, buprenorphine, and others
  - Relapse prevention
- Referral/coordination/linkages with other providers to ensure integration of services and better client care;
- Re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary;
- Development of follow-up plans;

Provider Qualifications
Education/Experience/Supervision

Professional diagnostic, therapeutic, and other treatment services under this service category must be provided by practitioners holding appropriate and valid California licensure or certification, including:

- Physicians (including Psychiatrists)
- Psychologists
- Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)
- California Alcohol and Drug Abuse Counselors (CADAC)

Other professional and non-professional ("waivered") staff ***may*** provide services appropriate for their level of training/education as part of a care team ***under the supervision*** of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Non-professional staff include but are not limited to:

- Peer Navigators
- Community Health Workers
- Trainees

Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training

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

- General HIV knowledge such as transmission, care, and prevention.
- Trauma and stigma for people living with HIV, and the effect of trauma and stigma on care/relapse
- Harm reduction principles and strategies
- Overdose education and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care

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

Service Characteristics

Substance Abuse Outpatient Care must be offered in a way that addresses barriers to accessing substance use disorder treatment and uses resources to support positive health outcomes for clients. All Substance Abuse Outpatient Care must include the Key Activities included in the *Service Definition* section of this document. Providers While not specifically required, other best practices recommended for this service include:

- Provision of low-threshold services; agency guidelines should avoid abstinence requirements tied to service provision
- Use of peer-based support strategies
- Use of a trauma-informed approach
- Use of reminder systems and flexible policies regarding missed appointments

Initial Appointments: Initial Substance Abuse Outpatient Care appointments should be made as soon as possible to avoid potential

drop out. Initial in-person contact (e.g., intake, initial screening, and scheduling of a full assessment) must occur no more than five business days after first client referral and must address immediate needs. Full assessments may occur later but no more than 30 calendar days after the initial in-person contact. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Orientation
Each new client enrolled in Substance Abuse Outpatient Care must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment
The substance use disorder provider must conduct a comprehensive face-to-face needs assessment within 35 days of referral. The needs assessment will describe the client's current status and inform the treatment plan. This substance use needs assessment should include:

- Substance use history
- Current medications and side effects
- A detailed statement of the client's current presenting problem
- Mental status exam (MSE)
- Concurrent diagnoses, including physical and mental health diagnoses

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

Treatment Plan
Frequency: An individualized treatment plan must be developed within 30 calendar days of the client's initial assessment and re-evaluated at least every six months thereafter, with adaptations as needed.

Requirements: Substance use disorder providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Identifies and prioritizes the client's mental health care needs, including those not directly related to substance use
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment

- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and substance use disorder team
- Identifies interventions, modalities, and resources to attain the goals and objectives, including referral and linkage to other relevant providers (e.g., mental health providers, physicians, housing specialists)
- Details frequency and expected duration of services
- Is signed and dated by the provider unless documented via the Care Plan in an electronic health record

Treatment Provision

Services should be provided utilizing methodologies appropriate for the client's needs, following evidence-based recommendations for substance use disorder treatment for people living with HIV. These may include any combination of:

Group and individual therapy/counseling: Outpatient substance use disorder counseling may be done in groups, individually, or a combination of the two.

Harm Reduction Model: Services should utilize harm reduction principles and should be offered for all substances as appropriate. Programs may include syringe access services, but services funded through Ryan White can only be provided to Ryan White clients and **cannot include purchase** of syringes.

Recovery readiness: Services should include an evaluation of the client's readiness to abstain from substance use for the foreseeable future.

Medication-assisted treatment: Licensed narcotic treatment programs may combine pharmacotherapy such as methadone, buprenorphine, and naloxone with counseling and behavioral therapy. Medications must be prescribed by a licensed and appropriately certified/registered medical provider (with buprenorphine certification, if applicable). *Note: buprenorphine services may also be provided under the Outpatient/Ambulatory Health Services category if preferred.*

Relapse prevention: Services should provide education and counseling to help prevent relapse. These may include recovery planning and self-help groups as well as coping strategies for common relapse triggers.

Referral / linkage: Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.

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

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

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

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

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

Adopted: _____ Date: 06/22/22

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Service Directives

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

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

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

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

INACTIVE

1. Determination of Eligibility

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

2. Timely Provision of Services

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

3. Share of Cost

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

4. Removal of Cap on Services

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

HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Child Care Services

No.: SSC 08
Date Approved: 7/23/03
Date Revised: 9/25/2024
Date Reviewed: 9/25/2024

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

HRSA Definition:
The HRSA RWHAP supports intermittent Child Care Services for the children living in the household of PLWH, who are HRSA RWHAP-eligible clients, for the purpose of enabling those clients to attend medical visits, related appointments, and/or HRSA RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care
- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)
- In alignment with the United States Health Resources Services Administration's Ryan White HIV/AIDS Program, Part D-funded Coordinated HIV Services for Women, Infants, Children and Youth (WICY), the age guidelines are: for infants are up to two years of age; children ages 2 to 12; and, youth are 13 to 24.
- In accordance with the California Department of Social Services, CalWORKs Child Care (https://www.cdss.ca.gov/calworks-child-care), child care is provided for children through the age of 12, and for exceptional needs and severely disabled children up to age 21.

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

Objective
Childcare Services are intended to maintain/improve a client's ability to maintain or access medical care.

Education/Experience/Supervision There are no minimum educational standards for staff providing childcare reimbursement services.

Individual supervision and guidance must be available to all staff as needed.

Staff Orientation and Training
Initial: All staff providing Childcare Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

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

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Intake
The Housing Services provider must ensure that the client intake has been performed prior to Ryan White service provision and if not, perform an intake. See the Universal Standards for detailed intake requirements. Providers should ensure that any consents specific to childcare services are completed and in the client's file.

Orientation
Each new client receiving childcare services must receive an orientation to provided services, and document this orientation in the client file.

Reassessment
The client's care plan must be updated at least every six months.

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

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

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

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

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

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

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

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

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

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

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

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

Signed: _____ Date: 09/25/2024

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Service Directives

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

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

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

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

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

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

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

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HIV Health Services Planning Council
Sacramento TGA

SERVICE STANDARDS

Subject: Utilities Assistance

No.: SSC 10
Date Approved: 7/23/03
Date Revised: 4/27/16
Date Reviewed: 4/27/16
Inactivated: 5/27/20

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NOTE: Utilities Assistance is not a funded service category under Policy Clarification Notice 16-02. Rather, it is a component of Emergency Financial Assistance. As such, the service standard for Utilities Assistance is being inactivated and will be included in the service standard for Emergency Financial Assistance.

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

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

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

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

3. Established Standards:

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

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

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

B. The term "utilities" shall be interpreted to include electric power, water and sewer service, natural gas and alternative heat sources such as propane, wood or fuel pellets for homes which use such fuels as the primary source of heating. Purchase of containerized water may be included for homes lacking either a piped water connection or a well.

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

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

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

5. Medical Case Managers at RW Agencies may at any time submit to the RW Fiscal Agent requests for interpretation of these or any other Services

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

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

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

Adopted: _____ Date: 5/27/20
Kristina Kendricks-Clark, Chair

INACTIVE

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Medical Transportation Services **No.: SSC 11**

Date Effective: 07/23/03
Date Revised: 01/22/25
Date Reviewed: 01/22/25

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Medical Transportation Services Standard will apply to all Ryan White contracted vendors that provide medical transportation services regardless of funding source (Part A or Part B).

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

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

3. Established Standards:

   A. Ryan White medical transportation funds must be prioritized by purpose:
      (1) medical appointments
      (2) Ryan White funded Core or Support Services
      (3) alternative healthcare appointments

(4) other critical needs as related to medical care needs, i.e., taking a client to an SSA appointment to maintain medical benefits

B. Ryan White medical transportation funds must be prioritized by means of transport so as to preserve the most cost-effective means Clients should utilize insurance coordinated rides before requesting Ryan White-funded bus passes and ridesharing, Ryan White is the payer of last resort.
- family, friends and other sources of transport for which the RW Agency does not incur any direct cost.
- volunteer services
- public transit (to include Paratransit)
- ride share (such as Lyft or Uber)
- taxi service

C. Ride Share Services
- Understand that Uber and Lyft are not the default option for transportation unless there's physical mobility problems or a patient's insurance doesn't provide coordinated rides through insurance.
- Clients who no-show their coordinated Lyft or Uber rides more than five times in the program year will be restricted from using ride share that program year unless prior authorization is made by the agency's management
- Rideshare service providers have the right to refuse service.

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

D. Medical Transportation services may be provided through:
- **Contracts with providers** of transportation services: Transportation services may be provided via contract or other local procurement mechanism that directly compensates the provider, including ride share, taxi, or van services.

- **Voucher or token** systems for ride-limited vouchers (i.e. not monthly unlimited passes) except in cases where it can be demonstrated that a monthly pass would be more cost-effective to enable access to medical and support services. Transportation services may be provided via contract or other local procurement mechanism that directly compensates the provider, including ride share, taxi, or van services.
- **Purchase or lease of organizational vehicles** for client transportation programs
    - The recipient must receive prior approval from OA and HRSA for the purchase of a vehicle
- **Organization and use of volunteer drivers**
    - Programs must specifically address insurance and other liability issues

Costs for transportation for providers or case managers to provide care should be categorized under the service being provided.

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

F. Unallowable costs include:
- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle:
    - The following expenses are not eligible for reimbursement:
        - Parking
        - Tires, vehicle maintenance, or repairs
        - Lease or loan payments
        - Insurance
        - License or registration fees
        - Motor vehicle violations

- Monthly unlimited public transportation passes, except in cases where it can be demonstrated and a necessary and more cost-effective option
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees
- Reimbursement to staff using personal vehicle to transport clients for Part B-funded medical transportation services.

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

Fiscal Management

There are additional requirements when utilizing vouchers, gas cards, taxi tokens, or bus tickets or passes.

- Providers must ensure that vouchers or store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services.
- General-use prepaid cards are considered equivalent to cash and are therefore unallowable. Such cards generally bear the logo of a payment network (e.g., Visa, MasterCard, or American Express) and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.
- Providers must have systems in place to account for disbursed vouchers. The systems must track client's name, staff person who distributed the voucher, date of the disbursement, voucher dollar amount, voucher serial number, and confirmation that the client went to their medical or support services appointment.
- Providers should only buy vouchers in amounts that are reasonable for use in the contract year. In no case should use of vouchers lead to monies being held over to future contract years.

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

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

Provider Qualifications

Medical Transportation Services may be provided directly by provider staff or volunteers, by staff of an outside company/agency (i.e., taxi service, ride share such as Lyft, paratransit), or by individuals such as family or friends.

Education / Experience / Supervision

There are no minimum educational standards. Agency staff providing medical transportation must:

- Have a valid California Driver's License with any endorsements required by California law (e.g., passenger endorsement if driving vehicles designed for >10 passengers)
- A copy of the driver's license must be retained on file at the provider agency
- Hold the minimum required amount of automobile insurance as required by law, and be enrolled in the Employer Pull Notice program and affiliated with the agency's requester code
- A copy of the driver's insurance must be retained on file at the provider agency

Staff Orientation and Training

Initial: All Ryan White-funded staff providing Medical Transportation Services 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, including HIV transmission
- Universal precautions
- Privacy requirements

Additional: Staff who directly provide Medical Transportation Services must also receive initial and ongoing safety training as appropriate for their position and required by federal, state, or local regulations.

Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes. Topics must include:

- Emergency equipment
- Defensive driving
- Cardiopulmonary Resuscitation (CPR) and first aid (renewed every two years)
- Pre-trip inspections

Vehicles

Any agency or staff vehicles used for client transportation must be registered, insured, and in safe operating condition. They must be equipped with seat belts and other safety equipment as appropriate.

- **Children:** If children are transported, child safety seats must be provided and installed by the child's parent or guardian. Seat type, installation, and use must comply with California state law.

- **Disabled clients:** Disabled clients must be transported in Americans with Disability Act (ADA)-compliant vehicles, and all staff and volunteers transporting clients with disabilities must be trained on how to properly and safely transport these clients.

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

Adopted: _____ Date: 01/22/2025

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Food Bank and Home Delivered Meals **No.:** SSC 12

Date Approved: 01/22/03
Date Revised: 12/11/24
Date Reviewed: 12/11/24

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

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

- Medically appropriate
- Nutritionally sound
- Consistent with any restrictions otherwise noted by an individualized client medically prescribed diet

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

2. Ryan White funding is to be expended in an equitable manner which is based upon verification of a client's budget and need that serves the contractually obligated number of unduplicated clients. Payment for Food Bank and Home-Delivered Meals services through Ryan White funding is authorized only in circumstances where client eligibility is validated, and any other payment guarantor is insufficient.

3. Ryan White funded Food Bank and Home Delivered Meals assistance is to supplement what is available through food banks and other local food resources. It is not intended to be the sole source of assistance.

4. Established Standards:

   A. Screening:
      i. Each new client enrolled in Food Bank/Home Delivered Meals must receive an orientation to the services, document this orientation in the client file.
      ii. Refer ineligible clients for Food Bank/Home-Delivered Meals services to another community-based organization or link them to another safety net provider as appropriate. Documentation of that referral must be in the client file and available upon request.

   B. Food Bank/Home-Delivered Meals refers to the provision of actual food items, hot meals, or vouchers to purchase food. This also includes the provision of essential non-food items. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service, covered under the Medical Nutrition Therapy standard.

      Allowable costs under the Food Bank/Home-Delivered Meals standard include:
      - Food items
      - Hot meals
      - Vouchers used to purchase food
      - Nutritional supplements, such as Ensure, may only be used in addition to food and not as the only offering to a client.

      Allowable essential non-food items are limited to the following:
      - Personal hygiene products
      - Household cleaning supplies

      Unallowable costs under the Food Bank/Home-Delivered Meals standard include:
      - Household appliances
      - Pet food
      - Alcohol, tobacco, or cannabis products
      - Clothing
      - Other non-essential products
      - Cash payments to clients
      - The provision of food is essential to wellbeing and must be based on need. It should not be used as an incentive to motivate clients to attend on-going appointments or take medication

C. Food distributed by food banks and others shall be fresh (for packaged food, not beyond recommended expiration dates), free from filth or vermin, and until distributed to consumers, properly stored and handled to maximize shelf life and minimize spoilage. Referrals shall only be made to food providers which have valid, current permits issued by the appropriate county health department or otherwise meet accepted community standards. It is recommended and preferred that food packages contain items which can be used together to create nutritionally complete meals for a minimum of ***three days*** per person or family. Referrals by service providers to food banks and other services which are not themselves recipients of Ryan White funding, shall be based in part on client feedback on their satisfaction with the quality of such services.

D. Expenditures for food shall be controlled to minimize opportunities for inappropriate use. Vouchers or debit cards shall be issued only to qualified clients and, if possible, for reasonable cost. Vouchers or cards must be labeled or coded to prevent purchase of alcoholic beverages, tobacco products, or games of chance. The following criteria must be met for voucher/card issuance:

i. Eligible clients must work with the client's care team to have an assessment to provide proof of need with each request and such proof must be documented and added to the case file.

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

iii. Fiscal Management
There are additional requirements when utilizing vouchers or store gift cards.

1. Providers must ensure that vouchers or store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services. Some stores may require program vouchers to exclude certain products such as tobacco and alcohol.

2. General-use prepaid cards are considered "cash equivalent" and therefore unallowable. Such cards generally bear the logo of a payment network (e.g., Visa, MasterCard, or American Express) and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are co-branded with the logo of a payment network and the logo of a

merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore not allowed.

3. Providers must have systems in place to account for disbursed vouchers. The systems must track the client's name, the staff person who distributed the voucher, the date of the disbursement, and serial number, and the voucher dollar amount.

4. Providers should only buy vouchers in amounts that are reasonable for use in the contract year. In no case should use of vouchers lead to large amounts of Ryan White monies being held over to new contract years.

E. Providers of Food Bank and Home-Delivered Meals Services shall not use their professional status as a means to promoting products in which they may have a financial interest in.

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

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

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

Education / Experience / Supervision

There are no minimum educational standards. Staff preparing food must be familiar with safe food handling practices and meet any federal, state, or local requirements around food preparation.

Staff Orientation and Training

Initial: All Food Bank/Home Delivered Meals staff 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:

- Safe food handling procedures
- Confidentiality
- Knowledge of key points of entry for other Ryan White services

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Agency

Any agency providing Food Bank/Home-Delivered Meals must comply with federal, state, and local regulations, including any required licensure or certification for the provision of food bank services and/or home-delivered meals. Where applicable, this also includes adherence to any necessary food handling standards or inspection requirements.

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

Adopted: _____ Date: 12/11/2024

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Complementary/Alternative Therapies Service Standards

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

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

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

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

3. In accordance with the above:

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

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

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

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

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

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

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

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

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Kane R. Ortega

Adopted: Date: 4/27/11

Kane Ortega, Chair

'HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Mental Health Services

No.: SSC 14
Date Approved: 12/13/06
Date Revised: 12/11/24
Date Reviewed: 12/11/24

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

Descriptions:
Mental health services are outpatient psychological and psychiatric treatment and counseling services for individuals living with HIV who have mental illness. They are conducted in an outpatient group, couple/family, or individual setting and provided by a mental health professional licensed or authorized within California to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers. **Services such as support groups provided by non-mental health professionals** should be reported under Psychosocial Support Services.

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

Policies:

1. The provision of Mental Health services shall be consistent with Service Standards 05 (SSC05) Eligibility & Fees for Ryan White Part A and Part B Services and consistent with the Mental Health Services program as outlined herein:

Ryan White funding is allocated for HIV/AIDS medical, psychosocial, and support services to ensure client access to and continuity of care. Mental Health Services are allowable only for people living with HIV/AIDS who are eligible to receive Ryan White services. A comprehensive medical plan of care will be individualized to client needs consistent with intervention that promotes an optimal state of wellness.

Treatment Provision
Services should be provided utilizing methodologies appropriate for the client's needs and following national recommendations for HIV mental health

care guidelines. Services for the Ryan White eligible client may include any combination of:

- Individual counseling/psychotherapy
- Family counseling/psychotherapy
- Couples counseling/psychotherapy
- Group psychotherapy/treatment
- Drop-in groups
- Crisis intervention
- Psychiatric medication assessment, prescription, and monitoring

Documentation: Completed individualized treatment plans must be signed and dated by a provider; "waivered" staff must obtain signature of supervising clinicians where required under California law.

Key activities of Mental Health Services include:

- Initial assessment of the client's service needs;
- With client input, develop a comprehensive, individualized treatment plan, including client centered goals and milestones;
- Treatment provision in individual, family, and/or group settings, crisis intervention, and psychiatric consultation;
- Referral/coordination/linkages with other providers to ensure integration of services and better client care;
- Re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary;
- Re-assessment of the client annually; and
- Development of follow-up plans.

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

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

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

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

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

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

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

Education/Experience/Supervision

Professional diagnostic and therapeutic services under this service category must be provided by practitioners holding appropriate, current, and valid California licensure or certification, including:

- Psychiatrists
- Psychologists
- Psychiatric Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)

Other professional staff may provide services appropriate for their level of training/education as part of a care team under the supervision of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Services provided by Peer Navigators, Community Health Workers and such should be provided under Psychosocial Services.

According to the CA Board of Behavioral Health Standards, individual supervision and guidance must be routinely provided to all staff.

Contract staff funded by HIV Care Services Program funding require Recipient approval.

Staff Orientation and Training

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

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

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

Legal and Ethical Obligations

Practitioners must be aware of and able to practice according to California state law and the code of ethics of their respective professional organizations. Obligations include the following:

- **Duty to treat:** Practitioners may not refuse treatment to a person in need because of fear or disapproval of someone's behavior, identity, or health status, including HIV.
- **Confidentiality:** Practitioners must maintain client confidentiality. Limits of confidentiality include danger to self or

others, grave disability, child/elder abuse and, in some cases, domestic violence.

- **Duty to warn:** Serious threats of violence against a reasonably identifiable victim must be reported. At present, California law does not consider a person with HIV engaging in behaviors that may put others at risk for HIV a circumstance that warrants breaking confidentiality.

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

Service Characteristics

Mental Health Services must be offered in a way that addresses barriers to accessing mental health care and uses resources to support positive health outcomes for clients.

Clients who otherwise qualify for Ryan White-funded services may not be denied services on the basis of current substance use. All Mental Health Services must include the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Initial Appointments: Initial Mental Health Services appointments should be made as soon as possible to avoid potential drop out. Initial intake appointments should occur within 10 days of first referral to assess immediate needs; full assessments must occur no later than 30 calendar days after first client referral and should be scheduled sooner whenever possible. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Emergency Appointments: Clients in crisis must be provided with Mental Health Services immediately or as soon as possible; regular intake and assessment procedures may be followed after the initial crisis has resolved.

Orientation

Each new client enrolled in Mental Health Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Initial Assessment

The mental health care provider must conduct a comprehensive face-to-face mental health needs assessment within 30 days of referral. The needs assessment will describe the client's current status and inform the treatment plan. The mental health assessment should include:

- A detailed statement of the client's current presenting problem
- A detailed mental health treatment history, including psychotropic medications
- Substance use history
- Mental status exam (MSE)
- All relevant Diagnostic and Statistical Manual of Mental Disorders (DSM-V) diagnoses

Referral / Linkage: Clients requiring specialized care should be referred for and linked to such care, with documentation of that referral in the client file and available upon request.

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

Treatment Plan

Frequency: An individualized treatment plan must be developed during the initial assessment and re-evaluated at least every six months with adaptations as needed.

Requirements: Mental health providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Identifies and prioritizes the client's mental health care needs
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment
- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and mental health team
- Identifies interventions, modalities, and resources to attain the goals and objectives, including referral and linkage to other relevant providers (e.g., substance abuse counselors, physicians, housing specialists)
- Details frequency and expected duration of services
- Is signed and dated by the provider unless documented via the Care Plan

The treatment plan should be reviewed and revised at each appointment as needed.

Re-Assessment

The mental health care provider must conduct an annual comprehensive face-to-face mental health re-assessment. The re-assessment will describe the client's status and inform the treatment plan. The mental health re-assessment should include:

- An updated statement of the client's current presenting problem
- An updated mental health treatment history, including psychotropic medications
- Updated substance use history
- Updated mental status exam (MSE)
- All relevant Diagnostic and Statistical Manual of Mental Disorders (DSM-V) diagnoses

Discharge

- Date of Last Session
- Reason for Discharge (Please Select)
  - Client expressed dissatisfaction with progress or results from treatment.
  - Client moved.
  - Goals met - successful case - mutual agreement of therapist and client.
  - Client dissatisfaction with therapist/agency.
  - Referred to a specialist or agency specializing in client's presenting problem
  - Unknown, client stopped attending, could not be reached to give reason for terminating.
  - Disagreement on relational case: some in family or couple wanted to continue, others didn't.
  - Therapist left the agency and client decided to terminate therapy in response in lieu of getting reassigned to another therapist.
- Total Number of Sessions
- Summary
- Presenting Problem at Intake
- Brief Summary of Treatment
- Level of Functioning at Discharge (include presenting problem improvement, no change, or regression)

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

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

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

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

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

Signed: _____ Date: 12/11/2024

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Housing Assistance Services

No.: SSC 15
Date Approved: 05/26/04
Date Revised: 06/26/24
Date Reviewed: 06/26/24

Consistent with the United States Health Resources Services Administration's (HRSA), Policy Clarification Notice 16-02 and the funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council, the following Housing Assistance Standard will apply to all County HIV Care Services Program contracted vendors that provide housing services.

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

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

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the client before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

    - CD4 **or** Viral Loads within the past 12 months
    - Release of information,
    - Grievance,
    - Rights and responsibilities,

- State ARIES/HIV Care Connect (HCC) forms, etc.

Reimbursement for services can only be paid for active clients meeting eligibility.

4. In accordance with the above:
   A. Definition:

Housing services provide transitional, short-term, or emergency housing assistance (including hotel/motel vouchers) to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and increase stability for clients, allowing them to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated at least every six months, to guide the client's linkage to permanent housing. Housing services also can include housing referral services; assessment, search, placement, and advocacy services; as well as payment of fees associated with these services. Providers must have written policies and procedures that indicate the percentages of a client's monthly rent they can pay through this program.

Allowable activities in this service category include:

- Housing that provides some type of core medical or support services, such as:
  - Residential substance use disorder services
  - Residential mental health services
  - Residential foster care
  - Assisted living residential services
- Housing that does not provide direct core medical or support services but is essential for a client or family to initiate or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. This includes paying or supplementing rent. In some cases, this can include hotel/motel vouchers, when done on a limited basis as part of an overall plan to transition the client to permanent housing.
- Housing referral services to other (non-Ryan White) housing programs

NOTE: Utilities, including firewood, may be paid for under the Emergency Financial Assistance service category, but are not allowable in this service category.

Unallowable Activities

Housing services **may not:**

- Be used for mortgage payments.
- Be in the form of direct cash payments to clients.
- Be used for rental or security deposits. Such deposits are typically returned to clients as cash, which would violate the prohibition on providing cash payments to clients.

Intake

The Housing Services provider must ensure that the client intake has been performed prior to Ryan White service provision and if not, perform an intake. See the Common Standards of Care for detailed intake requirements. Providers should ensure that any consents specific to housing are completed and in the client's file.

Orientation

Each new client receiving Housing Services must receive an orientation to provided services, document this orientation in the client file.

Housing Plan

Housing Service providers should create an individualized housing plan for each client. The plan must include:

- Assess current housing needs
- Incorporate client input
- Guide the client's linkage to permanent housing
- Include any referrals and linkages to other needed services
- Be signed and dated by staff providing Housing Services

Reassessment

The client's housing plan must be updated at least every six months.

Service Characteristics

Eligibility Screening: If the Housing Services provider is the client's first contact with a Ryan White service provider, the client must be screened for eligibility as described in the Common Standards of Care.

Newly Identified Clients: Housing Services providers should work with other Ryan White-funded subrecipients to ensure that newly diagnosed clients and clients new to the Ryan White system are evaluated for and provided with Housing Services as needed.

Appointments: Initial Housing Services appointments should be made as soon as possible to avoid housing disruptions. Appointments must occur no later than 10 calendar days after the first client referral, which can be a self-referral. Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after a request. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented in the file.

Duration: Services are intended to be temporary in nature. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24-months, if necessary, based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline. The Ryan White Recipient must be made aware of such an instance.

Documentation: All client contacts, as well as services, referrals, and other assistance provided to clients to help them obtain housing must be recorded in the client chart.

- If the client is not placed in housing that also provides some type of core medical or support services, the necessity of housing services to support treatment plan adherence must be documented.
- Documentation must include confirmed appointments for HIV-associated medical care, whether provided through their housing services provider or externally.

B. Instructions:

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

Clients must deplete other housing resources dollars, including HOPWA-eligible clients, before receiving rent subsidies through Ryan White. At no time will total housing assistance, whether provided solely through rent subsidies, move-in costs, or emergency housing, or through a combination thereof, exceed the equivalent of two months' rent, unless specific contractual agreements with funding sources provide extensions.

i. Rent Subsidies

a. Clients may receive rent subsidy assistance services once each fiscal year, not to exceed $1,000, unless additional assistance is authorized by the Recipient. Eligible Ryan White clients must meet the following criteria for eligibility for rent subsidy assistance:

1. Be in medical care and compliant with their case management plan.
2. Provide proof of pending eviction or 3-day notice of eviction.
3. Provide landlord name and tax identification information.

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

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

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

ii. Move-in Costs

a. A one-time annual payment of move-in cost, i.e. the first month's rent, may be paid
b. Client must have documentation of ongoing ability to maintain rental payments (e.g., check stub, disability income verification, etc.).
c. No deposits shall be paid as deposits are refundable to the client as a cash payment.

iii. Emergency Housing

a. Authorization to place a client in Emergency Housing must be approved by a licensed clinician or contracted subrecipients' Executive Director. Written documentation must be placed in the client's file.

b. No more than $1,800 per client, per year, for Emergency Housing can be used. Additional assistance must be approved by the TGA's Recipient.
c. Emergency housing may include motels, hotels, rooming houses, etc.
d. Emergency housing payments may be utilized on an emergency or transitional basis for no more than 14 nights per year, at the most reasonable rate available in the community for emergency per-diem housing which meets acceptability standards, unless specific contractual agreements with funding sources provide extensions or in the state or federally designated emergencies when additional nights are approved by the state or federal funder.
e. This assistance will be accompanied by a documented plan to obtain more permanent housing and such medical case management and advocacy as is needed to pursue the plan.

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

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

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

Education / Experience / Supervision

There are no minimum educational standards for Housing staff. Housing-related referrals must be provided by people who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.

Individual supervision and guidance must be available to all staff as needed.

Staff Orientation and Training

Initial: All staff providing Housing Services 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
- Local housing resources including HOPWA
- Privacy requirements
- Navigation of the local HIV system of care including ADAP

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar, and must be clearly documented and tracked for monitoring purposes.

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

Adopted: _____ Date: 06/26/2024

Kristina Kendricks-Clark, Vice Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Emergency Financial Assistance

No.: SSC 16
Date Approved: 05/26/04
Date Revised: 06/26/24
Date Reviewed: 06/26/24

NOTE: Other Critical Needs is not a funded service category under Policy Clarification Notice (PCN) 16-02. Rather, it is a component of Emergency Financial Assistance. As such, the service standard for Other Critical Needs was re-named to Emergency Financial Assistance. Additionally, the TGA's previous Utilities Assistance Service Standard (SSC10) was inactivated and incorporated into the Emergency Financial Assistance Service Standard on May 27, 2020, as it too is a component of Emergency Financial assistance and not a funded service under PCN 16-02.

Consistent with the United States Health Resources Services Administration's (HRSA), Policy Clarification Notice 16-02 and with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council, the following Emergency Financial Assistance will apply to all HIV Care Services Program subrecipients that provide Other Critical Needs services.

Emergency Financial Assistance provides limited one-time or short-term payments to assist a client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance (i.e., general fund relief, local non-profit services) will be effectively used and that any allocation of Ryan White funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client may not be funded through Emergency Financial Assistance.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which improves access and adherence to medical care. All such Other Critical Needs

services initiated by agencies receiving Ryan White funding will be related to sustaining continuity of healthcare as defined by HRSA.

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

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the client before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

    - CD4 **or** Viral Loads within the past 12 months
    - Release of information,
    - Grievance,
    - Rights and responsibilities,
    - State ARIES/HIV Care Connect (HCC) forms, etc.

    Reimbursement for services can only be paid for active clients meeting eligibility.

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

5. **Service Characteristics**
    Emergency Financial Assistance services are intended to provide emergency fiscal support for essential services to eligible clients for a limited time. Key characteristics include:

    Orientation
    Each new client enrolled in Emergency Financial Assistance must receive an orientation to the services on the first visit. Document this orientation in the client file.

    Eligibility Screening: If the Emergency Financial Assistance subrecipient is the client's first contact with a Ryan White-funded

provider, the client must be screened for eligibility as described in the Common Standards of Care.

Assessment: The Emergency Financial Assistance subrecipient will determine the need for emergency financial assistance. Clients must submit proof of the need (i.e., a utility shut-off notice). Emergency Financial Assistance funds can only be used as a last resort for payment of services and items for a short period of time (i.e., not indefinitely/ongoing). Ensure funds are only used to supplement, and not supplant, existing federal, state, or local funding for HIV-related services. Example: Funds may not be used for utilities if the client lives in housing through programs that include the cost of utilities (e.g. Section 8 housing).

Service Provision:
Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Emergency Financial Assistance provides limited one-time or short-term payments to assist clients with an urgent need for essential items or services necessary to improve health outcomes, including:

- Utilities: The term “utilities” shall be interpreted to include electric power, water and sewer service, natural gas and alternative heat sources such as propane, wood or fuel pellets for homes which use such fuels as the primary source of heating. Purchase of containerized water may be included for homes lacking either a piped water connection or a well.
- Housing Assistance requests must also comply with the Housing Service Standard (SSC15) and Housing Directive
    - Housing rent subsidy: One-time rent payments, for clients in permanent, or unsubsidized housing, not to exceed $1,000.
    - Emergency Housing Assistance: No more than $1,800 per client, per year, for Emergency Housing can be used. Not to exceed 14 nights per year.
- food (including groceries and food vouchers)
- transportation
- medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance

Program Guidance:
Emergency Financial Assistance funds used to pay for otherwise allowable services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted.

Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

All client contacts and other information pertinent to services must be recorded in the client chart.

Emergencies are defined as facing an imminent threat of losing basic utilities or access to needed medications. Funds are intended to help a client through a temporary, unplanned crisis to sustain a safe and healthy living environment.

When accessing Emergency Financial Assistance funds, clients must work with case managers or other service providers to develop a plan to avoid similar emergencies in the future. Changes should be made to the client's care plan, when relevant

Fiscal Management: Payments made on behalf of clients need to maintain client confidentiality and should not indicate "HIV" or "AIDS" on the check. If the name of the organization includes "HIV" or "AIDS", generic checks should be used.

Subrecipients must have systems in place to account for disbursed funds under EFA. The systems must track the client's name, the staff person who distributed the funds, the date of the disbursement, the recipient of the funds and the dollar amount. These data elements can be tracked on the ARIES/HCC Services screen if no other tracking system is available.

Unallowable Activities

This emergency financial assistance may not be used for:

- Ongoing payments for any services or goods for clients
- Direct cash payments to clients
- Activities that can be paid for under another Ryan White service category including ADAP or another payer source
- Funds may NOT be used for direct maintenance expense (tires, repairs, etc.) of a client's privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.
- Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).
- Funds may NOT be used for funerals, burial, cremation, or related expenses.

- Funds may NOT be used to purchase clothing.
- Funds may NOT be used to support employment, vocational, or employment-readiness services.

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

7. Standards applied include:

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

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

   c. Assessment findings must be documented in case notes.

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

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

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

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

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

Education/*Experience/Supervision*
There are no specific education or licensing requirements for Emergency Financial Assistance providers. Services must be provided by persons who possess knowledge of:

- Sources of emergency funding in the local community, including those offered by local utilities
- AIDS Drug Assistance Program (ADAP)
- HIV and related issues
- Understanding of the Ryan White CARE Program

Individual supervision and guidance must be routinely provided to all staff.

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

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

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes.

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

Adopted: _____ Date: 06/26/2024
Kristina Kendricks-Clark, Vice Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: HIV Psychosocial Support Group Service Standard **No.:** SSC 17

Date Approved: 12/01/04
Date Revised: 06/22/22
Date Reviewed: 06/22/22

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

Service Objective

The objective of Psychosocial Support Services is to increase client self-efficacy and create a broad-based support system that makes resources available as needed.

HRSA Service Definition

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns.

Program Guidance

Ryan White-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds under this service category may not be used to pay for nutritional supplements (See Food Bank/Home Delivered Meals service category), social/recreational activities, or gym memberships.

Funds under this service category may not be used to pay for services provided by a licensed mental health provider (see Mental Health Services service category.)

Key Activities

Key activities of Psychosocial Support Services may include:

- HIV support groups

- Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services for services provided by Registered Dietitians)
- Child abuse and neglect counseling
- Pastoral care/counseling services
- Bereavement counseling

Psychosocial Support Services can be provided in individual and/or group settings.

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

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

3. In accordance with the above:

Psychosocial Support Services must be offered in a way that addresses barriers to accessing health care and uses resources to support positive health outcomes for clients. When relevant, these services should be coordinated with a client's overarching Care Plan. All Psychosocial Support Services must include at least one of the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Eligibility Screening: If the Psychosocial Support Services provider is the client's first contact with Ryan White-funded services, the client must be screened for eligibility as described in the Universal Standards of Care.

Initial Psychosocial Support Services Appointments: Initial Psychosocial Support Services appointments should be made as soon as

possible to avoid potential drop out. Appointments must occur no later than 30 calendar days of first client referral, but should be scheduled sooner whenever possible. As clients may miss appointments, agencies must have a process in place to ensure timely follow up with clients, preferably within 24 hours. Missed appointments and attempts at rescheduling must be documented in the file.

Each new client enrolled in Psychosocial Support Services must receive an orientation to the services at the first visit; document this orientation in the client file.

Treatment Provision

Requirements: Treatment plans are recommended for high-acuity clients, although they are not generally required for this service category. Psychosocial Support Services providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Reviews and incorporates the existing Care Plan, if any
- Identifies the client's needs, personal support systems, and services they are currently receiving
- Includes individual and/or group counseling sessions
- Provides education and information that will enhance the client's well-being, including health education, risk reduction, drug/medication use, and nutritional information
- Provides allowable, needed services to family members and significant others with the goal of developing and strengthening the client's support system
- Coordinates with the client's existing providers, such as mental health and substance use case managers
- Coordinates and makes referrals to outside providers as needed
- Is signed and dated by the provider unless documented via the Care Plan in the client's file or electronic health record

Documentation: Psychosocial Support Services should be provided in a way that is consistent with the individual service plan. All services provided should be documented in the client's chart.

In accordance with above:

- Psychosocial Support Group services shall be led by an individual with documented experience and/or training in group dynamics and group facilitation. The leader must have knowledge and experience with HIV issues.

- Clients needing Psychosocial Support Group services should be placed in the support group most compatible with their life situations and/or experiences living with HIV.
- Ground rules and the groups' purpose shall be established and periodically evaluated for all support groups funded by Ryan White funds. The ground rules will be used to minimize interruption in productive group discussion. Ground rules will be reiterated prior to beginning each session.
- With the exception of the facilitator and guest presenters, participation in support groups shall be limited to individuals living with HIV (PLWH), as non-PLWH may intrude on trust and open discussion. Providers conducting Psychosocial Support Group services should have the ability to work with families of PLWH in a separate setting.
- Psychosocial Support Groups will be maintained at the size most conducive to productive sharing, listening, and discussion by all members.

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

Provider Qualifications

Education/Experience/Supervision

Psychosocial Support Services practitioners are not required to be licensed or registered in the State of California. Providers should be trained and knowledgeable in HIV-related issues. Individual supervision and guidance must be available to all staff as needed.

Exception: Pastoral care/counseling services must be provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, or as a component of services provided by a licensed provider, such as a home care or hospice provider).

Staff Orientation and Training

Initial: All Ryan White-funded staff providing Psychosocial Support Services must complete an initial training session related to their job description and

serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

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

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes.

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

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

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

Adopted: _____ Dated: 06/22/22

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

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

No.: SSC 18
Date Adopted: 09/22/10
Last Reviewed: 09/23/26
Date Approved: 09/23/26

Policy: The attached document represents the service standards to be utilized when providing Medical Nutrition Therapy to HIV Care Services (HCS) Program eligible clients in the Sacramento TGA. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the HIV Health Services Planning Council (herein after referred to as the Council).

As directed by the Council priorities, when funded, the following service standards will apply to HCS contracted service providers.

PURPOSE OF MEDICAL NUTRITION THERAPY

The Health Resources Services Administration (HRSA) defines Medical Nutrition Therapy (MNT) as services provided by a Registered Dietitian Nutritionist (RD) to assess, diagnose, and treat nutritional conditions and support overall health outcomes. MNT services are delivered as part of comprehensive, patient-centered care and may be provided independently by a RD in coordination with the interdisciplinary care team, as appropriate.

MNT services not provided by a RD shall be considered a support service. Nutrition-related resources and interventions may be incorporated as part of a comprehensive nutrition care plan, as appropriate to needs.

Key activities include:

- Nutrition assessment and screening;
- Dietary/nutritional evaluation and development of an individualized nutrition care plan;

- Coordination of nutrition-related resources, as appropriate;
- Nutrition education and counseling.

MNT services can be provided through individual, group-based, and/or virtual formats to support client engagement, access to care, and practical, skills-based learning that promotes sustainable dietary behavior change.

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

VALUES OF MEDICAL NUTRITION THERAPY:

MNT services are guided by the following principles:

- **Client focused** – The client and the Nutritionist will reach a consensus as to the client's nutritional needs, and as to the prioritization of those needs, which will culminate in the creation of an individualized nutrition plan of care.
- **Promotes health and engagement in care** – MNT supports clients in developing sustainable nutrition practices that contribute to overall health, chronic disease management, and continued engagement in medical care.
- **Committed to empowering the client** – MNT is an ongoing process that empowers clients' knowledge, skills, and confidence to support long-term self-management and independence.
- **Goal-oriented** – Specific mutually agreed upon nutritional goals will be set in client care plans in order to assess progress and effectiveness of Medical Nutritional Therapy.
- **A flexible model** – RDs will periodically reevaluate and be responsive to client's immediate, emerging, or otherwise changing nutritional needs.
- **Culturally proficient** – RDs must be able to address clients in terms and contexts that are understandable and account for the client's personal situation/environment.
- **Efficient and resource-conscious** – Services are delivered based on client need and aim to support effective use of healthcare resources, including prevention of higher-cost interventions when possible.
- **Accessible** – Services are provided in a non-discriminatory manner

and are accessible to all clients, regardless of gender, age, sexual orientation, ethnicity, religion, educational level, language, criminal history, substance use history, or ability to pay for services.
- **Collaborative** – MNT is integrated within the interdisciplinary care team, with coordination and referrals to medical providers and supportive services as appropriate.
- **Enhances access to care** – Services may include individual, group-based, and virtual formats to improve accessibility, flexibility, and client engagement, particularly for individuals facing barriers to in-person care.

GOALS OF MEDICAL NUTRITION THERAPY

The goal of medical nutritional therapy for PLWH/A is to:
- Optimize nutrition status and immunity;
- Prevent and address nutrient deficiencies;
- Promote the attainment and maintenance of optimal body weight and composition;
- Maximize the effectiveness of antiretroviral agents;
- Develop and implement individualized nutrition care plans in collaboration with the client;
- Promote communication and collaboration between the clients and all persons involved in the client's care;
- Support client access to nutrition education through various delivery methods;
- Educate the client on appropriate nutrition-related resources and assist them in accessing those resources.
- Improve client engagement, retention in care, and self-management through accessible and culturally relevant nutrition education approaches.

MEDICAL NUTRITION THERAPY EDUCATION REQUIREMENTS & TRAINING

MNT services are provided by RD credentialed by the Commission on Dietetic Registration and qualified to practice in the State of California.

Providers should be trained and knowledgeable in HIV-related care and its impact on nutritional status. Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training

Initial: All HCS-funded staff providing MNT services must complete an initial training aligned with their job responsibilities and the needs of people living with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, treatment, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP
- Cultural responsiveness and awareness of social determinants of health impacting care

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

MEDICAL NUTRITION THERAPY PROCESSES

MNT services are delivered using a structured, evidence-based approach consistent with the Nutrition Care Process, a nationally recognized framework established by the Academy of Nutrition and Dietetics, including assessment, diagnosis, intervention, and monitoring and evaluation.

Each new client enrolled in MNT must receive an orientation to the services at the initial visit, and this will be documented in the client record.

Core components of MNT include:

- Nutrition Assessment – Systematic collection and analysis of relevant nutrition-related data
- Nutrition Diagnosis – Identification of nutrition-related problems that can be addressed through intervention
- Nutrition Intervention – Development and implementation of individualized nutrition care plans, including education, counseling, and coordination of services
- Monitoring and Evaluation – Ongoing assessment of client progress, outcomes, and effectiveness of interventions

MNT services may include group-based nutrition education and skill-building activities to enhance client engagement, improve self-management, and address barriers to healthy eating.

INITIAL ASSESSMENT

Each client receiving MNT services will complete an initial nutrition assessment conducted by a RD. The assessment may be conducted in-person or via telehealth (video or phone), as appropriate.

The purpose of the assessment is to collect, analyze, and prioritize information which identifies client needs, barriers, and strengths for purposes of developing an individualized Care Plan. Assessment of the client's nutritional status will be conducted using a structured approach consistent with the Nutrition Care Process, a nationally recognized framework established by the Academy of Nutrition and Dietetics (e.g., ADIME framework), supported by clinical judgment and validated screening tools as appropriate.
At minimum, the initial assessment will include:

- Anthropometric Data: Height (if available), weight history, BMI, and weight trends.
- Medical and Clinical History: Relevant diagnoses (including HIV status and comorbidities), medications, laboratory data (if available), and overall health status.
- Nutrition Intake and Eating Patterns: Dietary intake, meal patterns, food preferences, and cultural considerations.
- Food Access and Social Determinants of Health (SDOH): Assessment of food security, access to food, housing stability, and other factors impacting nutritional status.
- Nutrition-Related Knowledge and Behaviors: Understanding of nutrition concepts, readiness to change, and self-management capacity.
- Nutrition Diagnosis and Risk Identification: Identification of nutrition-related problems using clinical judgment and/or validated assessment tools, as appropriate.

Clients receiving MNT services will be informed of their rights and responsibilities in accordance with Ryan White program and organizational policies at their initial visits.

This includes:

- Informed consent for participation in MNT services, documented in the client record.
- The client will be informed of their right to confidentiality and information privacy procedures.

- The client will be informed of the Release of Information Form and will be asked to provide consent to the appropriate release of information to other pertinent entities. Additionally, the Release of Information Form must be updated annually.
- The client will be informed of and agree to the Client's Rights and Responsibilities form.
- The client will be informed of the agency's Grievance Procedure.
- The client will be informed of the role and purpose of Medical Nutrition Therapy.

Documentation: All required intake forms and program documentation must be completed and maintained in accordance with Ryan White program and organizational policies.

Documentation must be retained in the client record and be available for monitoring and audit purposes.

Eligibility

Eligibility requirements for HCS can be found in SSC 05 – Eligibility and Fees for HCS.

CARE PLAN DEVELOPMENT

Based on assessment findings, the RD will develop and implement an individualized nutrition care plan in collaboration with the client.

The care plan may include:

- Individualized nutrition recommendations
- Education and counseling
- Goal setting (client-centered and measurable)
- Referrals to additional services or resources, as appropriate

Nutrition interventions may be delivered through individual, group-based, and/or virtual formats.

The RD will document in the client's electronic medical record that the Care Plan has been mutually agreed to by the client and the Registered Dietitian.

1. The nutrition care plan will be reviewed and updated periodically based on client needs, clinical status, and program requirements. Updates must be documented in the client record.

2. MNT services are provided in coordination with HIV medical care. Documentation of medical visits and clinical indicators (e.g., viral load, CD4 count) may be included in the client record, as available.

3. Nutrition interventions will be delivered in accordance with the individualized nutrition care plan. All services provided, including education, counseling, and any nutrition-related resources, must be documented in the client record.

CARE PLAN IMPLEMENTATION

The RD shall be available to assist the client in facilitating access to services when needed and/or provide advocacy assistance to help solve problems as necessary when barriers impede access.

The RD will always first attempt to encourage clients to resolve their challenges, and support clients in thinking through solutions before acting on behalf of the client to achieve nutritional care plan objectives.

Referral agencies shall be assessed for appropriateness to client situation and need. The referral process shall include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements shall be considered as a part of the referral process. Any referral made shall be appropriately documented in the client record.

NUTRITIONAL CARE PLAN FOLLOW-UP AND MONITORING

Periodic Care Plan follow up, and monitoring will be used to ensure that: 1) the care plan is adequate to meet client needs; 2) the client is actively pursuing Nutritional Care Plan objectives; 3) care is coordinated; and 4) changing or emerging needs are being addressed.

The RD will document all follow-up encounters and any updates to the nutrition care plan in the client record.

The RD will document in the client’s electronic medical record that the Care Plan has been mutually agreed to by the client and the RD at the time of each update.

The nutrition care plan will be reviewed and updated periodically based on client needs, clinical status, and program requirements. If the care plan remains appropriate and no revisions are indicated, this will be documented

in the client record.

REASSESSMENT

Clients receiving MNT services will undergo reassessment as needed to evaluate changes in nutritional status, clinical condition, and overall needs.

Reassessment will guide appropriate revisions in the Nutrition Care Plan and make informed decisions regarding discharge from medical nutritional therapy services and/or transition to other appropriate services.

Reassessment will be conducted utilizing the same process outlined for initial assessment.

TRANSFER AND DISCHARGE

A systematic process shall be in place to guide the transfer or discharge of clients from MNT services. This process includes appropriate documentation, communication with the client, and coordination of care to support continuity of services when needed.

Conditions under which Transfer/Discharge is appropriate:

- The client no longer requires MNT services or has met their nutrition-related goals
- Death of the client
- The client relocates or transfers care to another provider or service system
- The client and/or client's legal guardian requests that the case be closed
- The client is no longer eligible for services under program requirements
- Client is "lost to follow-up" (defined later)
- Client exhibits a pattern of abuse towards agency staff, property or improperly utilizing the service
- Client needs are more appropriately addressed in other programs
- Client provides false information or documentation.

Process for Transfer/Discharge

1. The reason for discharge or transfer will be documented in the client record.

2. When feasible, the client will be informed and provided with appropriate referrals or resources to support ongoing care.
3. Coordination with other providers or programs will be conducted as appropriate to support continuity of care
4. A discharge summary will be completed and included in the client record, documenting the reason for discharge and any relevant transition planning.

Criteria

A client may be considered "lost to follow-up" after reasonable efforts have been made to re-establish contact without success. Efforts to contact them should be documented in the medical record.

Grievance Process

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

Signed: Date: 09/23/26
Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Outreach Services Standard

No.: SSC 19
Date Approved: 12/08/10
Last Revised: 06/22/22
Date Reviewed: 06/22/22

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

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

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

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

3. PURPOSE OF OUTREACH SERVICES

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care. As such, Outreach Services provide the following activities: 1) identification of people who do not know their HIV status and/or 4) Linkage

or re-engagement of PLWH who know their status into HRSA RWHAP services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Outreach Services must:
1) use data to target populations and places that have a high probability of reaching PLWH who
   a. have never been tested and are undiagnosed,
   b. have been tested, diagnosed as HIV positive, but have not received their test results, or
   c. have been tested, know their HIV positive status, but are not in medical care;

2) be conducted at times and in places where there is a high probability that PLWH will be identified; and

3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Unallowable Activities
Outreach Services **may not:**
- Be used to pay for HIV counseling or testing
- Be used for outreach activities that exclusively promote HIV prevention education
- Be used for broad outreach activities, such as providing leaflets at a subway stop or posters at bus shelters
- Supplant funding for outreach activities funded by the Centers for Disease Control and Prevention or other federal, state, or local sources

GOALS OF OUTREACH SERVICES:
The goal of outreach services is to promote access to and engagement in appropriate services for <u>people living with HIV</u> who:
- are aware or unaware of their HIV status, but are not currently in care (unmet need);
- have fallen out of care or are at-risk of falling out of care;
- are self-managed or those who don't utilize the continuum of care;
- promote communication and collaboration between the clients and all persons involved in the client's care;
- Educate the client on available resources and assist them in accessing

those resources.

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

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

Staff Orientation and Training
Initial: All staff providing Outreach Services 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 HIV transmission, care and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including HOPWA and ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Service Characteristics
Outreach Services must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

Service Coordination: Services must be planned and delivered in coordination with local HIV prevention programs to avoid duplication of

effort. The services paid for by Ryan White under this standard cannot take the place of HIV prevention services offered by other programs.

Priority Populations: Services must be focused to populations and communities known to be at disproportionate risk of HIV infection. Broad-scope awareness activities for the general public, such as transit ads, are NOT considered focused services.

Key Locations: Services should be conducted at times and places where there is a high probability that people living with HIV will be reached. Examples of this include offering services at specific establishments frequented by people likely to have participated in high-risk behavior and offering services at times outside of normal business hours.

HIV Education: Clients should always be provided with HIV risk reduction and prevention education, information about partner services, and referrals to the HIV service delivery system including clear information on how to access those services.

Referral / Linkage: Clients should be referred for testing as appropriate; those testing positive for HIV should be referred and linked to HIV medical care, case management, benefits counseling, and other services necessary to maintain or improve health outcomes as appropriate, using a warm hand off where possible. Documentation of that referral must be in the client file and available upon request.

Partner Services: Per the California State Office of AIDS' Management Memo 15-06, Ryan White providers funded for Outreach Services must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Quantifiable: Providers should obtain client information and keep a record of each contact, including information/education provided and any referrals or linkages.

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

6. Clients shall have the right to request a review of any service denial from the agency that denied the service. The most recent review / grievance

policies and procedures for the RW Agency shall be made available to each client upon intake. A copy of the grievance policy, signed by the client, shall be maintained in the client's file.

Signed: _____ Date: 06/22/22

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Health Education and Risk Reduction Services Standard

No.: SSC 20
Date Approved: 12/08/10
Last Revised: 05/25/22
Date Reviewed: 05/25/22

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

HRSA Service Definition

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes counseling and sharing information about medical and support services with clients living with HIV to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., ADAP, qualified health plans through Covered California, Medi-Cal coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

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

1. Ryan White funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Health Education and Risk Reduction services, which are paid for through Ryan White (RW) funding

shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare (i.e. ADAP, Medi-Cal, etc.).

The provision of Health Education and Risk Reduction Services shall be consistent with Service Standards 05 (SSC05) Eligibility & Fees for Ryan White Part A and Part B Services and consistent with the Health Education and Risk Reduction Services program as outlined herein:

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

3. The purpose of Health Education and Risk Reduction services is to reach HIV+ persons and/or their sex and/or needle-sharing partners that reside in the Sacramento TGA. The primary focus is on those persons who receive and/or enter and remain in primary medical care for their HIV/AIDS related condition(s) and is intended to reduce HIV transmission by providing clients living with HIV with knowledge of risk factors for HIV transmission and actions they can take to reduce risk of transmission.

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

Health Education/Risk Reduction may be provided in individual and group settings. These programs should be delivered only to clients; affected individuals (partners and family members not living with HIV) are not eligible unless receiving services concurrently with the client. Health Education/Risk Reduction may NOT be delivered anonymously.

Activities should:

- address the prevention and risk reduction needs of *specific* populations at risk for HIV infection due to their sexual and drug related high risk behavior

- be culturally and linguistically appropriate for the targeted populations
- focus on enhancing the skills and capacities needed to implement personal risk reduction strategies

5. Contracted Service Providers requirements:

Provider Qualifications

Education/Experience/Supervision

There are no minimum educational standards for Health Education/Risk Reduction staff. All Health Education/Risk Reduction staff must be trained and knowledgeable about HIV and familiar with available HIV resources in the area. They should have good communication skills and be culturally competent.

Regardless of education/training, staff should be experienced in all of the following:

- Health education/risk reduction strategies and best practices
- HIV transmission and prevention
- Local HIV service delivery system, especially medical and support services and counseling

Individual supervision and guidance must be available to Health Education/Risk Reduction staff as needed.

Staff Orientation and Training

Initial: All staff providing Health Education/Risk Reduction 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 HIV transmission, care and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP
- Completion of the Passport to Partner Services training national curriculum, Tracks A and B. https://www.cdc.gov/std/training/passport-partner-services.htm or https://www.train.org/cdctrain/training_plan/4299
- Completion of the Introduction to Telephone Interviewing for DIS (Course ID 1090632): https://www.train.org/cdctrain/course/1090632/

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-

person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Service Characteristics

Health Education/Risk Reduction must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients.

HIV education: Clients should always be provided with HIV risk reduction and prevention education, partner services information, and an overview of the HIV service delivery system including clear information on how to access those services. Clients must also be provided with counseling about how to improve their health status and reduce the risk of HIV transmission to others.

Referral / Linkage: Clients should be referred for medical and support services as appropriate; documentation of that referral must be in the client file and available upon
request.

Partner Services: Per the California Department of Public Health's, State Office of AIDS, Management Memo 15-06, Ryan White providers funded for Health Education/Risk Reduction must have a process for Partner Services referral and counseling for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Additionally:

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

B. Establish and implement policies and procedures which :

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

2. Incorporate and ensure compliance with ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality (Civil Codes 38.1, 38.2, 38.3, Evidence Code I 012).

3. Ensure that Partner Services Counselors are trained in Partner Services Basic I "HIV Disclosure and Partner Services Training for Partner Services" conducted by the County of Sacramento, Division of Public Health.

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

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

C. Perform an intake process for each client meeting eligibility criteria for Ryan White services and shall reassess each client's eligibility for Ryan White funds annually as required by HRSA. The intake process shall include determining the client's eligibility for Ryan White funded services, completing the Ryan White Intake Form, and providing the client with an orientation to services. The intake process shall be conducted within a maximum of 30 days of initial client contact, unless the agency can no longer accept clients as a result of lack of funding or available staff. Clients placed on a waiting list shall be provided with referrals to alternate Ryan White agencies if alternatives exist, and all waiting lists shall be reported to the Service Performance Monitor at the mandatory Service Provider Caucus meetings. Once funding or staff becomes available, clients placed on the waiting list shall be seen in order of need.

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

E. Comply with "SSC 05 Eligibility & Fees for Ryan White Funded Services", "HIV Health Services Planning Council Current General

Directives and Service Directives", and all other applicable Service Standards found in CONTRACTOR's *Ryan White Care Program Sacramento TGA Contractor's Orientation Manual.*

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

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

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

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

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

Adopted: _____ Date: 05/25/22
Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

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

No.: SSC 21
Date Approved: 12/12/12
Last Revised: 09/23/26
Date Reviewed: 09/23/26

Policy: This document represents the service standards to be utilized when providing Non-medical Case Management services to HIV Care Services (HCS) eligible clients in the Sacramento TGA. This standard is to be used in conjunction with other service standards for medical, psychosocial and support services as developed and approved by the Sacramento TGA HIV Health Services Planning Council (herein after referred to as the Council).

As directed by the Council, when funded, the following service standards will apply to HIV Care Services Program contracted service providers.

1. HCS funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Non-medical Case Management services which are paid for through HCS funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare (i.e. AIDS Drug Assistance Program [ADAP], Medi-Cal, etc.).

2. HCS funding is to be expended in a cost effective, equitable manner, which is based upon verified client need and encourages self-empowerment of clients. Non-medical Case Management services paid for with HCS funds shall be provided in accordance with the allocation priorities and directives adopted by the Council, or through an alternative assessment process administered by a HCS-funded subrecipient.

3. The purpose of Non-Medical Case Management services is to provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case Management services may also include assisting eligible clients to obtain access to other public and

private programs for which they may be eligible, such as Medi-Cal, Medicare Part D, AIDS Drug Assistance Program (ADAP), Health Insurance Premium Payment (OAHIPP),Disability Insurance, Housing Opportunities for Persons With AIDS (HOPWA), Social Security, Pharmaceutical Manufacturer's patient assistance programs, Covered California, or other state or local health care and supportive services. This service category can be delivered through several methods of communication including face-to-face contact, phone contact, and any other forms of communication deemed appropriate.

Key activities for Non-Medical Case Management include:

- First appointment within 10 days of referral to screen for eligibility (if needed) and assign a non-medical case manager;
- Initial assessment of the client's service needs within 30 days of the first visit;
- Development of a comprehensive, individualized care plan during the initial assessment visit including client-centered goals and milestones;
- Ongoing client monitoring to determine the efficacy of the care plan;
- Re-evaluation of the care plan with the client at least every 6 months with revisions and adjustments as necessary;
- Ongoing assessment of the client's and other key family members' needs and personal support systems.

Benefits and Eligibility Services include the following activities or services:

- Assessing clients' need for financial and health care benefits
- Informing clients of various public and private financial and healthcare benefits that he/she may be eligible for
- Determining client eligibility for benefits
- Working with clients in making informed choices which maximize their available benefit
- Assisting clients to understand the disability and/or benefits application process and/or appeal process
- Assisting clients in understanding, applying and completing appropriate forms/paperwork for public and private financial, disability, and health care benefits
- Assisting clients through the stages of applying for financial, health care and/or disability benefits
- Working with clients to obtain the proper eligibility documentation needed to apply for benefits
- Provides education to the patient/client on responsibilities for co-pays, deductibles, share of cost, sliding fee scales, annual income caps and insurance coverage
- Works closely with case managers, case workers, physicians and outside agencies to ensure positive outcome for eligibility determination
- Providing clients with accurate information on available resources in the

community

Service Characteristics
Non-Medical Case Management must be offered in a way that addresses barriers to accessing medical care and uses resources to support positive health outcomes for clients. All Non-Medical Case Management services must include at a minimum the Key Activities included in the Service Definition section of this document. Other key characteristics include:

Eligibility Screening: If the Non-Medical Case Manager is the client's first contact with the HCS program, the client must be screened for eligibility as described in the Common Standards of Care.

Initial Non-Medical Case Management Appointments: Initial Non-Medical Case Management appointments should be made as soon as possible to avoid potential drop-out. Appointments must occur no later than 10 calendar days after first client referral. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up, preferably within 24 hours. Missed appointments and case management attempts at rescheduling must be documented in the file.

Referral/Linkage: Clients ineligible for Non-Medical Case Management services through HCS must be referred to another community-based organization or linked to another safety net provider as appropriate utilizing a warm hand off when possible. Documentation of that referral must be in the client file and available upon request.

Primary Case Manager: Each client should always have a primary case manager who helps coordinate services with other members of the treatment and services team. This primary case manager (who may or may not be the Non-Medical Case Manager) will serve as the main point person for the client to streamline communication and maximize care coordination.

Partner Services: Subrecipients funded for Non-Medical Case Management must have a process for Partner Services counseling and referral for clients. Partner Services information should be offered and referrals made for clients according to established processes.

Intake
The Non-Medical Case Manager must ensure that the client intake has been performed at the start of service provision and perform an intake if one has not previously been completed. See the Common Standards of Care for detailed intake requirements.

Orientation
Each new client enrolled in Non-Medical Case Management must receive an orientation to the services; document this orientation in the client file.

Initial Assessment
The Non-Medical Case Manager must conduct a face-to-face psychosocial needs assessment within 30 days of the start of Non-Medical Case Management services. The needs assessment will describe the client's current status and identify their strengths and weaknesses, resources, and/or stressors in order to develop a care plan which allows the patient to function and manage their condition as independently as possible. This assessment must be thoroughly documented and should be client-centered (the client may defer or choose not to discuss any specific issues during the assessment). Topics for discussion during the assessment should include:

- Current healthcare and social service providers (including Case Management offered elsewhere);
- Level of engagement in health care services;
- Current medications and adherence;
- Immediate health concerns;
- Substance use history and needs;
- Mental health / psychiatric history and needs;
- Level of HIV health literacy;
- Awareness of safer sex practices;
- Sexual orientation and gender identity;
- Sexual history;
- Self-management skills and history;
- History of incarceration;
- Family composition;
- Living situation and housing needs;
- History and risk of abuse, neglect, and exploitation;
- Social community supports;
- Food/clothing needs;
- Transportation needs;
- Legal needs;
- Financial / program entitlement;
- Emergency financial assistance needs and history;
- Partner services needs; and
- Summary of unmet needs.

Development of Care Plan
Existing Care Plan: When an existing care plan is present (e.g., if the client has received other HCS services), that care plan should be reviewed and utilized in the creation of the Non-Medical Case Management care plan. The Non-Medical Case Management care plan should be made available to other providers as needed for care coordination.

Frequency: An individualized care plan must be developed during the initial assessment and re-evaluated at least every 6 months with modifications as needed.

Requirements: Non-Medical Case Managers developing an individualized care plan should ensure that the plan, at a minimum:

- Is individualized and incorporates client input;
- Prioritizes the needs identified in the Initial Assessment;
- Identifies resources to meet the needs identified in the Initial Assessment and provides referrals to other relevant providers (e.g. substance abuse counselors, physicians, housing specialists);
- Includes specific measurable goals and objectives with activities and timeframes to meet each objective; and
- Encourages a client's active participation and empowers the client to become self-sufficient.

Clients with significant unmet medical needs should be referred to Medical Case Management for additional support in improving health outcomes.

Updates: As the client's status changes, the client and case manager must work together to establish new goals, objectives, and timelines.

Documentation: Care plans can be documented in paper charts or electronic health records. Copies of completed individualized care plans must be retained in the client file, signed by both client and provider if paper based. Client and provider must also sign any updated plans if paper based.

Quality Assurance and Supervision: All agencies providing Non-Medical Case Management must have a quality assurance plan in place describing a supervisory review to assess documentation of client's needs and if those needs were addressed. Annually, a representative sample of at least 10 percent of charts of active Non-Medical Case Management clients must have a supervisor review. All clients who are discharged from Non-Medical Case Management must also have a supervisor review within 3 months of discharge. Supervisors' reviews must be documented in the client chart with signature, date of review, and findings.

Client Record: All Non-Medical Case Management activities including but not limited to all contacts and attempted contacts with or on behalf of clients and coordination with referral agencies, must be recorded in the client record as soon as possible Documentation of activities must be legible, signed, and dated by the Non-Medical Case Manager.

Client Monitoring

Follow-Up and Monitoring. Non-Medical Case Management is an ongoing process.

Follow-up and monitoring ensures that:

- The resources provided are sufficient to meet the client's needs
- The client is working toward their care plan objectives
- New or changing needs are addressed

During monitoring, the Non-Medical Case Manager should follow-up on referrals, linkage, and assess whether the client has further needs. Frequency of follow-up is dependent on client needs and may be done in-person, or by phone; however, follow-up should occur at least annually at the time of re-certification.

Lost to Follow-up. 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. See the *Client Transfer and Case Closure* section of this document.

Reassessment/Revision of Care Plan

Non-Medical Case Managers should routinely review the successes and challenges clients are having in achieving outcomes as outlined in the care plan, measure progress in meeting goals and objectives, and revise the plan as necessary.

Revision of care plan: Client assessment and revision to the care plan as appropriate must be made at least every six months, or more frequently as client condition changes.

Documentation: Non-Medical Case Managers must routinely document the outcome of reassessments and service activities in the client record, client contact form, and outcome log (if applicable). Any changes to the care plan should be signed and dated by both the Non-Medical Case Manager and the client if paper based.

Feedback: Non-Medical Case Managers must provide constructive feedback to clients when reviewing the care plan and progress made toward goals and objectives. Constructive feedback is based on concrete observations and is focused on providing information to the client in a non-judgmental way. Feedback should be strengths-based whenever possible.

Client Transfer and Case Closure

Transfer of Clients: In the event that a client wishes to (or needs to) transition into Non-Medical Case Management services offered by another agency, relevant intake documents should be forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained. Transfer of clients between agencies or case managers is initiated when:

- The client notifies the case manager that they have moved to a different service area
- The client notifies the case manager of their intent to transfer services
- The Forced Disenrollment Grievance Procedure has been followed as defined in the Common Standards of Care, or
- The agency no longer receives funding

Case Closure: Agencies should close a client's file according to the written procedures established by the agency, as well as those outlined in the Common Standards of Care.

A client file may be closed under any of the conditions listed in the Common Standards of Care. Additional circumstances for closing a Non-Medical Case Management case include:

- The client no longer demonstrates need for Non-Medical Case Management due to their own ability to effectively advocate for their needs.
    - Agencies must have written Protocol to "graduate" clients out of Non-Medical Case Management including specific criteria for determining that the client is ready to graduate.
- A client is being incarcerated for more than 6 months.
    - If a client's incarceration is for a period of 6 months or less, the Non-Medical Case Manager should coordinate services with correctional medical staff in order to ensure continuity of case management upon release.
- The client is transitioning into Non-Medical Case Management services offered by another agency, as described above.

Education/Experience/Supervision

The experience standards are to ensure all staff providing benefits and eligibility services are properly trained and have an understanding of the scope of their job responsibilities.

The educational requirements for a Non-Medical Case Manager include any health or human services bachelor's degree from an accredited college or

university. Licensure is not required. Examples of health or human services fields include, but are not limited to:

- Nursing
- Social Work
- Counseling
- Psychology
- Gerontology
- Clinical Pharmacy

Non-Medical Case Managers who do not meet this minimum educational level may substitute related direct consumer service experience under the supervision of a health and human services professional for a period of two years of full-time work, regardless of academic preparation.

Additional Skills:

- Ability to learn complex information on specialized benefits such as Social Security, Consolidated Omnibus Budget Reconciliation Act (COBRA), Medi-Cal, ADAP and welfare, as well as state and federal laws regarding disability benefits
- Experience working and/or volunteering in direct client services within a social service setting
- Ability to provide one-on-one counseling and advocacy
- Skill and ability in working with a diverse clientele including but not limited to heterosexual, homosexual, bisexual, transgender, people of color, substance users, homeless, immigrants, veterans, previously incarcerated, and/or individuals with mental health issues
- Ability to enter accurate information into various databases

All Non-Medical Case Managers must be trained and knowledgeable about HIV and familiar with available HIV resources in the area.

Staff Orientation and Training

Initial: All staff providing Non-Medical Case Management 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 HIV transmission, care and prevention
- Privacy requirements and Health Insurance Portability and Accountability Act (HIPAA) regulations
- Navigation of the local system of HIV care
- Basic case management skills

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinars, and must be clearly documented and tracked for monitoring purposes.

Caseload: Non-Medical Case Managers are expected to maintain a caseload of between 30 and 75 clients, per 1.0 FTE, at any given time depending on client acuity. (State Office of AIDS has a monitoring component for this.)

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

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

6. HCS funded subrecipients may, at any time, submit to the Recipient requests for interpretation of these or any other Services Standards adopted by the Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

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

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

Signed: _____ Date: 09/23/26
Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Health Insurance Premium and Cost-Sharing Assistance Program

No.: SSC 22
Date Approved: 09/24/14
Date Revised: 06/22/22
Date Reviewed: 06/22/22

Purpose:

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

1. Policy:

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

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

Part A and B Services and Sacramento TGA's Health Insurance Premium and Cost-Sharing Assistance program.

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

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

2. Provider Requirements

Staff Orientation and Training

Initial: All staff providing Health Insurance and Cost-Sharing Assistance must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

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

Ongoing: Staff must also receive ongoing annual training as appropriate for their position.

Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar, and must be clearly documented and tracked for monitoring purposes.

Intake

The Health Insurance and Cost-Sharing Assistance provider must ensure that the client intake has been performed prior to Ryan White service provision and if not, perform an intake. See the Universal Standards of Care for detailed intake requirements. Providers should ensure that any consents specific to Health Insurance and Cost-Sharing Assistance are completed and in the client's file.

Orientation

Each new client receiving Health Insurance and Cost-Sharing Assistance must receive an orientation to provided services; document this orientation in the client file.

Care Plan

Health Insurance and Cost-Sharing Assistance providers should create an individualized care plan for each client. The plan must include:

- Assess current health insurance needs
- Incorporate client input
- Include any referrals and linkages to other needed services
- Be signed and dated by staff providing Ryan White Services

Reassessment

The client's care plan must be updated at least every six months.

3. Established Standards:

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

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

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

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

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

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

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

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

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

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

- Must be the payer of last resort

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

- Clients under 100% FPL in states that do not implement Medicaid (Medi-Cal) expansion;
- Clients with incomes above 500% FPL;
- Clients who have minimum essential coverage other than individual market coverage (*e.g.,* Medicaid, CHIP, TRICARE, employer-sponsored coverage, and certain other coverage defined in Internal Revenue Code Section 5000(a)) available to them, but choose to purchase in the Marketplace; and
- Clients who are ineligible to purchase insurance through the Marketplace.

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

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

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

Signed: _____

Richard Benavidez, Chair Date: 06/22/22

Comprehensive Health Care Coverage

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

Are you a lawfully present California resident? Under the Affordable Care Act (ACA), California residents are able to obtain affordable health care coverage, regardless of any pre-existing conditions. Lawfully present California residents can obtain health insurance through Covered California. If you are eligible for an Advanced Premium Tax Credit (APTC) or state subsidy offered through Covered California, you must select the full amount to be applied to your premium.

For more information or to enroll, visit the Covered California website (https://www.coveredca.com) or call (800) 300-1506. Please refer to the following map (https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=8d08ae9fff0d49f996d855e51fc8d971) to find an ADAP site that also manages Covered California enrollment.

Starting 2020 if you don't get coverage, you may have to pay a tax penalty that could be up to $2,100 per family, based on 2.5% of your household income or a minimum of $695 per adult, whichever is greater!

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

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

When can I enroll in health coverage? Open Enrollment for Covered California is generally from October 15 through January 15. Special Enrollment periods occur within 60 days of a qualifying life event such as: involuntary loss of health insurance, becoming a permanent resident of the State of California, birth of a child, a change in marital status, etc. If you would like to enroll in a non-Covered California health insurance plan, please contact the health plan directly to inquire about their open enrollment period dates.

I am eligible for Medicare Part D, how do I enroll? Medicare eligible beneficiaries may enroll in either a Prescription Drug Plan or a Medicare Advantage Drug Plan during open enrollment or 3 months prior to their 65th birthday, including the month they turn 65, and 3 months after their 65th birthday. Open enrollment for Medicare Part D is generally from mid-October through early-December.

Get help paying for your health insurance costs! Once you enroll in a health insurance plan, you can enroll in an ADAP insurance assistance program. An insurance assistance program pays for your health insurance or Medicare Part D premiums, outpatient medical out-of-pocket costs, including Medicare Part B, up to the healthcare plan's annual out-of-pocket maximum.

Talk to your enrollment worker for more information or call 844-421-7050.

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

Client's Signature: _____ Date: _____

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

CDPH 8445 (10/19)

SAMPLE RYAN WHITE CARE PROGRAM

CLIENT REFUND AGREEMENT

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

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

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

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

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

By signing below, I agree to the conditions above.

_____ _____
Signature Date

_____ _____
Witness Date

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Substance Abuse Treatment Services – Residential **No.:** SSC 23

Date Approved: 07/26/00
Date Revised: 06/22/22
Date Reviewed: 06/22/22

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council the following Substance Abuse Treatment Services Standard will apply to all Ryan White contracted vendors that provide these services. This standard applies to both detoxification (detox) and residential treatment services and will be referred to as Substance Abuse treatment services.

NOTE: *For clarity and consistency, the service category referenced throughout this document is "Substance Abuse Services (residential)", per PCN #16-02. However, in all other cases, the TGA utilizes 2016 White House Office on National Drug Control Policy (ONDCP) language, including "substance use disorder" instead of "substance abuse".*

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

1. The provision of Substance Abuse Treatment Services – Residential shall be consistent with Service Standards 05 Eligibility & Fees for Ryan White Part A and Part B Services (SSC05) and consistent with the Substance Abuse Treatment Services – Residential as outlined herein:

2. Clients presenting through self-referral will be accepted and authorized for Substance Abuse Treatment Services – Residential through Ryan White funding only in circumstances where client eligibility is validated and no other payment guarantor has been identified.

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

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

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

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

      i. HIV related medical issues must always take precedent over substance abuse treatment program protocol.
      ii. Any therapeutic treatment model must be tailored for those clients with extreme HIV related medical issues (as determined by a medical provider) not suitable for social model intervention.

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

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

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

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

Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis and treatment of substance use disorder. Services include:

- Screening
- Assessment
- Diagnosis and/or treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Medication-assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention
    - Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Key Activities

Key activities of Substance Abuse Services (residential) include:

- Short-term room and board to support treatment of substance use disorder;
- Initial assessment of the client's service needs;
- Pretreatment/recovery readiness programs and relapse prevention strategies;
- Harm reduction, including syringe access;
- Development of an individualized treatment plan with client-driven goals and milestones;
- Treatment provision, including:
    - Behavioral health counseling in individual, family, and/or group settings
    - Crisis intervention
    - Medication-assisted therapy, including the use of disulfiram, acamprosate, naltrexone, methadone, buprenorphine, and others
    - Relapse prevention

- Referrals to detoxification services;
- Coordination/linkages with other providers to ensure integration of services and better client care;

- Re-evaluation of the treatment plan with the client at least every six months with revisions and adjustments as necessary; and
- Development of follow-up and discharge plans.

Objective
Substance Abuse Services (residential) is designed to assist clients in reducing and/or eliminating use of alcohol, legal, and/or illegal drugs through harm reduction strategies in order to improve the overall health and social wellness of HIV-positive adults.

Provider Qualifications
Education/Experience/Supervision
Professional diagnostic, therapeutic, and other treatment services under this service category must be provided by practitioners holding appropriate and valid California licensure or certification, including:

- Physicians (including Psychiatrists)
- Psychologists
- Nurse Specialists/Practitioners
- Marriage and Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)
- California Alcohol and Drug Abuse Counselors (CADAC)

At least 30% of program staff providing counseling services in a substance use treatment program must be licensed or certified pursuant to the requirements of California Code of Regulations, Title 9, Division 4, Chapter 8.

Other professional and non-professional ("waivered") staff may provide services appropriate for their level of training/education, as part of a care team under the supervision of a licensed or certified clinician.

Other professional staff include but are not limited to:

- Interns
- Assistants
- Fellows
- Associates

Non-professional staff include but are not limited to:

- Peer Navigators
- Community Health Workers
- Trainees

Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training

Initial: All Ryan White-funded staff providing Substance Abuse Services (residential) must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention.
- Trauma and stigma for people living with HIV, and the effect of trauma and stigma on care/relapse
- Harm reduction principles and strategies
- Overdose education and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including ADAP

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

Facility

Any agency providing medication-assisted treatment for substance use disorder must be accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). If the facility primarily provides inpatient medical or psychiatric care, the component providing the residential substance use treatment must be separately licensed for that purpose.

Service Characteristics

Substance Abuse Services (residential) must be offered in a way that addresses barriers to accessing substance use disorder treatment and uses resources to support positive health outcomes for clients. All Substance Abuse Services (residential) must include the Key Activities included in the ***Service Definition*** section of this document.

While not specifically required, other best practices recommended for this service include:

- Provision of low-threshold services; agency guidelines should avoid abstinence requirements tied to service provision
- Use of peer-based support strategies

- Use of a trauma-informed approach

Orientation
Each new client enrolled in Substance Abuse Services (residential) must receive an orientation to the services on admission; document this orientation in the client file.

Initial Assessment
The substance use disorder provider must conduct a comprehensive initial assessment for services. The needs assessment will describe the client's current status and inform the treatment plan. The substance use needs assessment should include:

- Substance use history
- Current medications and side effects
- A detailed statement of the client's current presenting problem
- Mental status exam (MSE)
- Concurrent diagnoses, including physical and mental health diagnoses

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

Treatment Plan
Frequency: An individualized treatment plan must be developed upon the client's admission, and re-evaluated at least every 90 days thereafter or more frequently if needed.
Requirements: Substance use disorder providers developing an individualized treatment plan should ensure that the plan, at a minimum:

- Incorporates client input
- Includes a statement of the problems, diagnoses, symptoms, or behaviors to be addressed in treatment
- Identifies and prioritizes the client's mental health care needs, including those not directly related to substance use
- Sets realistic and measurable goals, objectives, and timelines based on client needs identified by the client and substance use disorder team
- Include a plan for adherence to the HIV medical plan
- Details expected duration of services
- Ensures coordination of care, through collaboration with the client's service providers (medical provider, case manager, mental health specialist, etc.)

- Is signed and dated by the provider, unless documented via the Care Plan in an electronic health record

Discharge: The treatment plan must detail the terms of discharge, including the conditions that must be met for discharge to occur, and ways in which care will be coordinated with the client's outpatient case manager or other supportive person, to help prevent relapse.

Treatment Provision
Services should be provided utilizing methodologies appropriate for the client's needs, following evidence-based recommendations for substance use disorder treatment for people living with HIV. These may include any combination of:

Group and individual therapy/counseling: Substance use disorder counseling may be done in groups, individually, or a combination of the two.

Harm Reduction Model: Services should utilize harm reduction principles and should be offered for all substances as appropriate. Programs may include syringe access services, but **cannot include purchase** of syringes.

Recovery readiness: Services should include an evaluation of the client's readiness to abstain from substance use for the foreseeable future.

Medication-assisted treatment: Licensed narcotic treatment programs may combine pharmacotherapy such as methadone, buprenorphine, and naloxone with counseling and behavioral therapy. Medications must be prescribed by a licensed and appropriately certified/registered medical provider. *Note: buprenorphine services may also be provided under the Outpatient/Ambulatory Health Services category if preferred.*

Relapse prevention: Services should provide education and counseling to help prevent relapse. These may include recovery planning and self-help groups as well as coping strategies for common relapse triggers.

Referral / linkage: Clients requiring specialized care should be referred for and linked to such care utilizing a warm hand off when possible, with documentation of that referral in the client file and available upon request.

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

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

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

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

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

Adopted: _____ Date: 06/22/22

Richard Benavidez, Chair

HIV Health Services Planning Council

Sacramento TGA
Part A and B

Policy and Procedure Manual

Subject: Outpatient Ambulatory Health Services

No.: SSC 24
Date Adopted: 06/25/2025
Date Reviewed:06/25/2025
Date Approved:06/25/2025

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Council, the following Outpatient Ambulatory Health Services Standard will apply to all HIV Care Services Program contracted subrecipients that provide outpatient ambulatory health services.

Descriptions:
This document describes the "Outpatient/Ambulatory Health Services" service category of the Sacramento County's HIV Care Services Program, funded through the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A and B. It serves as a supplement to the Universal Standards document.

This document highlights each of the requirements and standards that apply to Outpatient/Ambulatory Health Services and must be followed by any subrecipient receiving HIV Care Services funding for this service category.

In addition to the Universal Standards of Care, providers of Ryan White CARE Act funded services must also meet additional standards that are specific to the service they are funded to provide.

1. Outpatient and Ambulatory Medical Care (including laboratory tests)
   Outpatient and Ambulatory Medical Care is the provision of professional diagnostic and therapeutic services rendered by a licensed physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room and urgent care services are not considered to be outpatient settings. Services include diagnostic testing, early intervention and risk assessment, medical history taking, physical examination, diagnosis and

treatment of common physical and mental conditions, behavioral risk assessment (including subsequent counseling and referral), preventive care and screening, pediatric development assessment and well-baby care, prescribing and managing medication therapy, education and counseling on health issues, treatment adherence (provided in the context of outpatient medical care), continuing care and management of chronic conditions, referral to and provision of specialty care (including all medical subspecialties), and laboratory testing integral to the treatment of HIV infection and related complications.

Outpatient medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

These standards for Outpatient and Ambulatory Medical Care are designed to ensure that agencies:

1. Provide and coordinate high quality care for the routine needs of clients with complex medical conditions;
2. Assess and respond appropriately to the physical, psychosocial, cognitive and therapeutic needs of clients; and
3. Coordinate care with collateral service providers and systems to ensure optimal client care and provide appropriate referrals for assessment and treatment.

	STANDARD	MEASURE
1.1	Care is provided by health care professionals certified in California to prescribe medications in an outpatient setting such as a clinic, medical office, or mobile van.	• Documentation of all applicable licensures, certifications, registrations, or accreditations is available for review.
1.2	Providers have specific experience and appropriate training in caring for HIV infected clients or access to such expertise through consultations.	• Documentation -- such as Continuing Education Units (CEUs) and Advanced HIV/AIDS Certified Registered Nurse (AACRN) certification for nurse practitioners – is present in personnel files and available for review. • Consultation relationships are documented by signed memoranda of understanding. • Condition is confirmed by review of applicable documentation in service records.

1.3	HIV medical care is consistent with current PHS guidelines.	• Condition is confirmed by review of applicable documentation in service records. • Aggregate results in comparison to HRSA's Performance Measure Portfolio, particularly the Core Measures and the current Sacramento County HIV Care Services Clinical Quality Management Plan Performance Measures, are compiled annually and available for review.
1.4	Only allowable services are provided.	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.
1.5	Services are provided as part of the treatment of HIV infection.	• Condition is confirmed by review of applicable documentation in service records.
1.6	Specialty medical care is related to HIV infection or conditions arising from the use of HIV medications (i.e., side effects).	• Condition is confirmed by review of applicable documentation in service records.
1.7	All tests are: • Integral to the treatment of HIV and related complications, necessary based on established clinical practice, and ordered by a registered, certified, licensed provider; • Consistent with medical and laboratory standards; and • Approved by the Food and Drug Administration (FDA) and certified under the Clinical Laboratory Improvement Amendments (CLIA) program.	• Condition is confirmed by review of applicable documentation in service records.
1.8	A treatment plan exists that is appropriate to each client's age, gender, and specific needs, and that both provider and client have reviewed. Plans include, at a minimum: • Diagnostic information; • Referrals (as appropriate); • Discussion of risk reduction, HIV education, secondary prevention, and behavior modification (as appropriate); • Prophylaxis against opportunistic infections;	• Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by review of patient satisfaction survey results regarding level of involvement and understanding of treatment plan.

	• Preventive care (e.g., mammograms, pap smears, prostate screenings) that is age, gender, and health-status appropriate; • Medications (including a current list of prescribed medication or notations explaining the absence of prescriptions); and • Education related to treatment adherence and the management of side effects (as appropriate).	
1.9	There is evidence of implementation of the treatment plan.	• Condition is confirmed by review of applicable documentation in service • records.
1.10	Psychosocial, mental health and substance abuse screenings are conducted in the context of Outpatient and Ambulatory Medical Care within 30 days of the initial client visit and are reassessed annually.	• Condition is confirmed by review of applicable documentation in service records.
1.11	When psychosocial, mental health, or substance abuse needs are identified, clients are referred to a case manager or appropriate service provider.	• Condition is confirmed by review of applicable documentation in service • records.
1.12	Staff follow-up with clients who miss medical visits to address barriers and to reschedule the appointment.	• Condition is confirmed by review of applicable documentation in service records.
1.13	Service is not provided in an emergency room, hospital, or any other type of inpatient treatment center.	• Condition is confirmed during a site visit or other physical observation. • Condition is confirmed by review of applicable documentation in service records. • Condition is confirmed by a review of submitted claims or other contract monitoring activities.

HIV Health Services Planning Council
Sacramento TGA
Part A and B
Policy and Procedure Manual

Subject: Home and Community-Based Health Services

No.: SSC25
Date Adopted: 09/24/25
Date Reviewed: 09/24/25
Date Approved: 09/24/25

Policy: Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council (herein after referred to as the Council), the following Home and Community-Based Health Services Standard will apply to all HIV Care Services (HCS) Program contracted subrecipients that provide the services.

Descriptions:
This document describes the "Home and Community-Based Health Services" service category of the Sacramento County's HCS Program, funded through the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A and/or B. It serves as a supplement to the Universal Standards document.

This document highlights each of the requirements and standards that apply to Home and Community-Based Health Services and must be followed by any subrecipient receiving HIV Care Services funding for this service category.

HRSA Service Definition
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Staffing Requirements and Qualifications
Quality services start with well-prepared and qualified staff. To ensure this, Ryan White subrecipients must meet all of the following requirements and qualifications:

• **HIV Knowledge and Training.** Staff should have training and experience with HIV related issues and concerns. At a minimum, staff providing Home Health or Home and Community-Based Health Services should possess knowledge about the following and will have completed an initial and annual education session in at least one (1) of the topics listed below. Education can include round table discussion, training, one-on-one educational sessions, in-service, or literature review.

- HIV disease process and current medical treatments
- Privacy requirements and Health Insurance Portability and Accountability Act (HIPAA) regulations
- Psychosocial issues related to HIV
- Cultural issues related to communities affected by HIV
- Adherence to medication regimens
- Human sexuality, gender, and sexual orientation affirming care
- Diagnosis and assessment of HIV-related health issues
- Transmission of HIV and other communicable diseases
- Harm reduction strategies

• **Licensure.** All staff must hold the appropriate degrees, certifications, licenses, permits, or other appropriate qualifying documentation as required by the Federal, State, County and/or municipal authorities.

<u>Home and Community-Based Health Services:</u>

- Licensed health care workers such as registered nurses, licensed vocational nurses, marriage and family therapists, licensed clinical social workers, physical therapists, and occupational therapists will maintain appropriate licenses and/or credentials as required by the State of California.
- Paraprofessionals employees such as certified nursing assistants and homemakers/home health aides will maintain appropriate licenses and/or credentials as required by the State of California (such as Home Health Aide Certification issued by the state of California).

• **Legal and Ethical Obligations.** Staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Obligations include the following:

- <u>Duty to treat</u>: Staff have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV.

- Confidentiality: Maintenance of confidentiality is a primary legal and ethical responsibility of the service provider. Limits of confidentiality include danger to self or others, grave disability, child/elder/dependent adult abuse. Domestic Violence must be reported according to California mandated reporting laws.
- Duty to warn: Serious threats of violence (including physical violence, serious bodily harm, death, and terrorist threats) against a reasonably identifiable victim must be reported. However, at present, in California, a PLWH engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Staff should follow their agency's policies and procedures in relation to duty to warn.
- Culturally Appropriate: Staff shall possess the ability to provide services to accommodate clients with disabilities, including communication barriers (services for clients who may have concerns such as hard of hearing, low literacy skills, and/or visually impaired) and culturally appropriate services for PLWH.
- Staff are advised to seek legal advice when they are unsure about particular issues and the legal/ethical ramifications of their actions.

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Service Management
Home and Community-Based Health Services:
To qualify for Home and Community-Based Health Services, the client must meet ALL of the following:

- Meet eligibility screening and payer of last resort criteria (assess lack of health insurance or coverage for nutritional supplements)
- Have a signed nurse referral or prescribed by client's physician
- Documentation of symptoms that impair ability to carry on normal daily activities
- Be re-screened for eligibility/qualification annually with periodic checks

Once client registration and screening have been conducted, the provider may provide services. Service management shall be consistent with the following principles:

Home and Community-Based Health Services Service Delivery

- Signed initial assessment (to include safety assessment of client's home and needs assessment) conducted by a licensed home and community-based health service workers (as outlined under Licensure on Page 2) within two (2) weeks of enrollment

- Development of a comprehensive individualized treatment plan re-evaluated at least every six (6) months
- Signed and dated care plan and progress notes
- Notes on care provision indicating type of service, location of service, date of service, and signature of provider
- Documentation of continued need every six (6) months
- Document of coordination with primary medical provider and/ a licensed home and community-based health service workers (as outlined under Licensure on Page 2) for continuity of care as needed.

- Confidentiality
  - Service provider agencies shall have a policy regarding informing clients of privacy rights, including use of Notice of Privacy Practices. For agencies and information covered by the Health Insurance Portability and Accountability Act (HIPAA), providers shall comply with HIPAA guidelines and regulations for confidentiality.

- Compliance with Standards and Laws
  - Service directors and managers shall ensure compliance with all relevant laws, regulations, policies, procedures, and other requirements designed to enforce service standards and quality.
  - Home and Community-Based services shall be consistent with standards set forth in this document.

Case Closure

Home and Community-Based Health services can be critical to a client's health. Discharge from these services may negatively affect the client's overall health. As such, discharge or termination of services must be carefully considered, and reasonable steps must be taken to ensure clients who need services are maintained in services. Additionally, the services provided are based on the needs of the clients and their attempt to access services. As such, discharge or termination of services may be independent from other services.

A client may be suspended or terminated from services due to the following conditions:

- The client has successfully attained health goals
- The client has become ineligible for services (e.g., due to relocation outside the service area or other eligibility requirements)
- The client chooses to terminate services
- The client's needs would be better served by another agency
- The client demonstrates unacceptable behavior that violates client rights and responsibilities
- The client cannot be located
- The client has died

Notice of Action/Discharge
Clients shall be given notice of discharge 30 days in advance of the proposed date of discharge.

Right to Dispute Discharge
Clients have a right to dispute the action/discharge as outline in Item 5 on page 6 below.

Documented Discharge Summary
A discharge summary shall be documented in the client's record. The discharge summary shall include the following items listed below.

- Documentation of no demonstrated need in closure in client record
- Copy of notification in client record
    - For clients with no known address or who are unable to receive mail, documentation of other types of notification or attempt at notification in client record
- Client service closure summary to include:
    - Circumstances and reasons for discharge
    - Date and staff signature and/or initials

As directed by the Council priorities, when funded, the following service standards will apply to HCS Program subrecipients.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Home and Community-Based Health services, which are paid for through Ryan White (RW) funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare.

2. Ryan White funding is to be expended in a cost effective, equitable manner, which is based upon verified client need and encourages self-empowerment of clients. Home and Community-Based Health services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Council, or through an alternative assessment process administered by a HCS Program subrecipient.

3. HCS Program subrecipients may at any time submit to the HCS Program Recipient requests for interpretation of these or any other Services Standards adopted by the Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

4. Coordination with other components of the HCS Program system of care is critical and required.

5. All HCS Program subrecipient must have an internal grievance process in place. Each client must receive a copy of the agency's grievance policy, and a signed copy of the grievance policy must be maintained in the clients' file. Information about how to access this process must be posted conspicuously in public areas of the agency. It must include provisions for informing clients of its existence, and how to begin the process. Clients also have the right to file a grievance with appropriate state licensing agencies (i.e. California Department of Health Care Services https://www.dhcs.ca.gov/services/Pages/Home-and-Community-Based-Services-(HCBS)%E2%80%93Grievance-and-Hearings.aspx).

6. All HCS Program subrecipients must have a quality assurance program and plan in place that is in compliance with the TGA's Quality Management / Continuous Quality Improvement Plan and requirements set forth by the Quality Management Manager of the Recipient.

Signed: _____ Date: 09/25/25
Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Part A and B
Policy and Procedure Manual

Subject: Linguistic Services

No.: SSC26
Date Adopted: 09/24/25
Date Reviewed: 09/24/25
Date Approved: 09/24/25

Policy: Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council (herein after referred to as the Council), the following Linguistic Services Standard will apply to all HIV Care Services (HCS) Program contracted subrecipients that provide linguistic services.

Descriptions:
This document describes the "Linguistic Services" service category of the Sacramento County's HCS Program, funded through the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A and/or B. It serves as a supplement to the Universal Standards document.

This document highlights each of the requirements and standards that apply to Linguistic Services and must be followed by any subrecipient receiving HIV Care Services funding for this service category.

Service Definition
HRSA Definition
Linguistic Services include interpretation and translation activities, both oral and written to eligible clients. These activities must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the subrecipient and client and/or support delivery of HRSA RWHAP-eligible services.

As directed by the Council priorities, when funded, the following service standards will apply to HCS Program subrecipients.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Linguistic services, which are paid for through Ryan White (RW) funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare.

2. Ryan White funding is to be expended in a cost effective, equitable manner, which is based upon verified client need and encourages self-empowerment of clients. Linguistic services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Council, or through an alternative assessment process administered by a HCS Program subrecipient.

Program Guidance:
These standards for Linguistic Services are designed to ensure that:

- Language is not barrier to any client seeking HIV related medical care and support; and
- Linguistic services are provided in a culturally appropriate manner.

Linguistic Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and, if applicable, hold relevant State or Local certifications.

Agencies provide linguistic services, including American Sign Language (ASL), as a component of HIV service delivery to facilitate communication between the client and provider, as well as support service delivery in both group and individual settings. These standards ensure that language is not a barrier to any client seeking HIV-related medical care and support, and that agencies provide linguistic services in a culturally appropriate manner. Services are intended to be inclusive of all individuals and not limited to any population group or set of groups. They are especially designed to ensure that all racial, ethnic, and linguistic populations living with HIV receive quality, unbiased services

Family and friends are not considered adequate substitutes for interpreters because of privacy, confidentiality, and medical terminology issues. If a client chooses to have a family member or friend as their interpreter, the provider must obtain written and signed consent form in the client's language. Family members or friends must be over the age of 18.

Objective

- The goal of Linguistic Services is to ensure that clients with a preferred language other than English are able to effectively communicate with providers.

Key Activities

Key activities of Linguistic Services include:

- Oral interpretation of conversations between clients and providers in the client's preferred language, and
- Written translation of documents to the client's preferred language whenever possible, including posted materials relevant to HIV services. When an agency does not have capacity to translate written materials to a language not typically spoken in their jurisdiction, oral translation of these documents may be provided instead.
- Linguistic services may be provided in group or individual settings; funds may also be used to pay for translating printed materials.
- Interpretation services may be provided by language lines.

Assessment

- Clients will be assessed for Linguistic Services within three (3) business days of intake.
- Provider will assess clients for interpretation, and/or other translation needs, as evidenced by limited English proficiency, impairment and/or other communication needs.

Service Provision

- Agency staff provides or coordinates the provision of linguistic services that addresses the client's identified needs within three (3) business days of intake.
- Agency staff will reassess clients' need for Linguistic Services on an annual basis.
- Subrecipients respond to requests for services in a timely manner and work with other providers to arrange appointments in a manner that minimizes the scheduling burden for the client.
- To minimize losses due to clients who do not appear for scheduled appointments, subrecipients contact the client directly at least once following the scheduling of the service but prior to the service date to confirm the appointment.
- Subrecipients deliver linguistic services in a manner that is sensitive to the culture of the client.
- Subrecipients have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the client seeking assistance
- Agencies shall provide Linguistic services for the date of scheduled appointment per request submitted and will document the type of linguistic service provided in the client's record.
    a. Linguistic services may be provided in person or via telephonic or other electronic means.
- Maintain progress notes of all communication between provider and client (or on behalf of client), including messages left for the provider.

Progress notes must indicate the service provided and referrals that link clients to needed services. Documentation should be noted in the client's record within three (3) business days of occurrence.

- Subrecipients track all services delivered to ensure quality and appropriateness.

3. HCS Program subrecipients may at any time submit to the HCS Program Recipient requests for interpretation of these or any other Services Standards adopted by the Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

4. Coordination with other components of the HCS Program system of care is critical and required.

5. All HCS Program subrecipient must have an internal grievance process in place. Each client must receive a copy of the agency's grievance policy, and a signed copy of the grievance policy must be maintained in the clients' file. Information about how to access this process must be posted conspicuously in public areas of the agency. It must include provisions for informing clients of its existence, and how to begin the process. Clients also have the right to file a grievance with appropriate state licensing agencies (i.e. U.S. Department of Health and Human Services through the Office for Civil Rights https://www.hhs.gov/civil-rights/filing-a-complaint/index.html#:~:text=social%20service%20provider.-,File%20a%20Complaint%20Online,via%20the%20OCR%20Complaint%20Portal).

6. All HCS Program subrecipients must have a quality assurance program and plan in place that is in compliance with the TGA's Quality Management / Continuous Quality Improvement Plan and requirements set forth by the Quality Management Manager of the Recipient.

Signed: _____ Date: 09/25/25

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA
Part A and B
Policy and Procedure Manual

Subject: Other Professional Services

No.: SSC27
Date Adopted: 09/24/25
Date Reviewed: 09/24/25
Date Approved: 09/24/25

Policy: Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council (herein after referred to as the Council), the following Legal Services Standard will apply to all HIV Care Services (HCS) Program contracted subrecipients that provide Legal services.

Descriptions:
This document describes the "Legal Services" service category of the Sacramento County's HCS Program, funded through the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) Parts A and/or B. It serves as a supplement to the Universal Standards document.

This document highlights each of the requirements and standards that apply to Legal Services and must be followed by any subrecipient receiving HIV Care Services funding for this service category.

HRSA Service Definition
Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the HRSA RWHAP-eligible PLWH and involving legal matters related to or arising from their HIV disease, including:

  - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
  - Interventions necessary to ensure access to all other legal services to maintain care
  - Preparation of:
    - Healthcare power of attorney

    - Durable powers of attorney
    - Living wills

- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption

- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for individuals receiving premium tax credits.

- RWHAP funds may be used to aid in the expungement of criminal records. Expungement of criminal records is an effective way to remove barriers to care and services, protect privacy, mitigate stigma, and support successful reentry into the community. To the extent that expunging a client's record is done to assist in obtaining access to services and benefits that will improve HIV-related health outcomes, RWHAP funds can be used to pay for the expungement of criminal records and associated costs.

GOALS OF THE STANDARDS

These standards of care are provided to ensure that Ryan White-funded legal services:

- Are accessible to all persons living with HIV who meet eligibility requirements
- Are provided by licensed or otherwise qualified individuals
- Are accessible both culturally and geographically to clients
- Provide individualized services for each client
- Focus on the most urgent and pressing needs of clients
- Reduce the effects of HIV discrimination and barriers in all environments
- Allow documentation of clients' wishes such as wills and do not resuscitate orders
- Secure benefits for clients
- Provide linkages for additional services if the agency is unable to provide them
- Coordinates client care with primary care medical clinics to ensure integration of services and the best care for each individual client.

Staffing and Educational Requirements

Quality legal services start with well-prepared and qualified staff. To ensure this:

- **HIV Knowledge.** Legal staff should have training and experience with HIV related issues and concerns. At a minimum, individuals providing legal services to people with HIV should possess knowledge about the following:
  - HIV disease process and current medical treatments
  - Psychosocial issues related to HIV
  - Cultural issues related to communities affected by HIV
- **Licensure.** All staff must hold the appropriate degrees, certifications, licenses, permits, or other appropriate qualifying documentation as required by the Federal, State, County or municipal authorities
  - Attorneys are licensed to practice law in the state of California and have a minimum educational level of a doctorate in Jurisprudence
  - Non-licensed staff, such as law students and other legal professionals, are supervised by attorneys
- **Legal and Ethical Obligations.** Legal staff must be aware of and able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Legal staff must be current with their continuing education requirements.
- **Culturally Appropriate.** Practitioners shall possess the ability to provide developmentally and culturally appropriate care to clients living with HIV.
- **Training.** Staff shall remain trained and knowledgeable in current legal issues in accordance with the rules of the State Bar of California. Staff will have knowledge of legal issues that may impact the legal assistance of people living with HIV. They will have the skills and ability to specialize in areas relevant to individuals living with HIV.
  - Agency paid staff and contractors must complete a minimum of two hours of HIV specific training annually
  - New staff and volunteers must complete two hours of HIV specific training within 90 days of start date

Case Closure

Legal services can be critical to maintaining a client's health and overall wellbeing. Discharge from legal services may negatively impact a client's overall health. As such, discharge or termination of services must be carefully considered, and reasonable steps must be taken to ensure that clients who need legal services are maintained in services.

A client may be suspended or terminated from legal services due to the following conditions:

- The client has died.
- The client has become ineligible for services (e.g., due to relocation outside the service area or other eligibility requirements).
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client has had no direct program contact in the past six months.

The following describe components of discharge planning:

- If the client has missed appointments and is at risk of suspension or termination of services, the legal provider will provide follow-up including telephone calls, written correspondence and/or direct contact, to strive to maintain a client's participation in care. Provider, within the constraints of previously signed releases of information, may work with the case manager to locate the client.
- The provider shall contact the client or the caregiver, in person, by phone, or with a formal letter, to explain why he/she is being discharged. If the client does not agree with the reason for discharge, he/she should be informed of the provider's grievance procedure.
- A discharge summary should be documented in the client's record. The discharge summary shall include the following:
  - Circumstances and reasons for discharge
  - Summary of service provided
  - Goals completed during services
  - Referrals and linkages provided at discharge as appropriate
- The provider shall close out the client in data collection system as soon as possible within thirty (30) days of case termination.
- A client may be discharged if his/her needs would be better served by another agency and is transferred to that agency. If the client is transferring to another provider, and the other provider will participate in the process, case closure should be preceded by a transition plan. To ensure a smooth transition, relevant intake documents may be forwarded to the new service provider. Providers from the two agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained, with appropriate Release of Information.

Program Guidance: Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

As directed by the Council priorities, when funded, the following service standards will apply to HCS Program subrecipients.

1. Ryan White funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which significantly improve access and adherence to such medical services. As such, any Legal services, which are paid for through Ryan White (RW) funding shall be related to HIV healthcare or other social support service appointments related to maintaining healthcare.

2. Ryan White funding is to be expended in a cost effective, equitable manner, which is based upon verified client need and encourages self-empowerment of clients. Legal services paid for with Ryan White funds shall be provided in accordance with the allocation priorities and directives adopted by the Council, or through an alternative assessment process administered by a HCS Program subrecipient.

3. HCS Program subrecipients may at any time submit to the HCS Program Recipient requests for interpretation of these or any other Services Standards adopted by the Council, based on the unique healthcare needs of a client or on unique barriers to accessing healthcare services which may be experienced by a client.

4. Coordination with other components of the HCS Program system of care is critical and required.

5. All HCS Program subrecipient must have an internal grievance process in place. Each client must receive a copy of the agency's grievance policy, and a signed copy of the grievance policy must be maintained in the clients' file. Information about how to access this process must be posted conspicuously in public areas of the agency. It must include provisions for informing clients of its existence, and how to begin the process. Clients also have the right to file a grievance with appropriate state licensing agencies (i.e. California State Bar https://www.calbar.ca.gov/Public/Complaints-Claims/How-to-File-a-Complaint).

6. All HCS Program subrecipients must have a quality assurance program and plan in place that is in compliance with the TGA's Quality

Management / Continuous Quality Improvement Plan and requirements set forth by the Quality Management Manager of the Recipient.

Signed: _____ Date: 09/25/25

Richard Benavidez, Chair