Minnesota Ryan White HIV/AIDS Program
Service Area Standards: Referral for Health Care/Supportive Services

HRSA Definition: Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance: Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported underthe Outpatient/Ambulatory Health Services category. Referrals for health care and support services provided by case managers (medical and non- medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Universal Standards: All subrecipients must meet universal standards requirements in addition to service area standards for which they arefunded.

Standard	Measure	Data Source
Individual Client Focused Standards		
1.0 Linkage should be appropriate to client situation, lifestyle, and need. The process includes timely follow up with client to ensure that services are received. Eligibility requirements for the referred service should be considered as part of the linkage process. Each client receiving Linkage Services will receive linkage referrals to those services critical to achieving optimal health and well-being. Depending on need, this may include any Ryan White Core Medical or Support Service or other services that reduce barriers to accessing core medical services or meeting basic needs.	1.0 Subrecipient will initiate linkages that are agreed to by the client and which may include: • Referral to a specific agency or health care provider • Contact information (including name, email address, and phone number) of a contact personat the referral agency • An exact address • A website address • Assistance with making and keeping appointments • Information on agency eligibility requirements	1.0 All of the elements of linkage referrals are documented in client file.
1.1 Subrecipient will facilitate Linkage Referrals by obtaining releases of information to permit provision of informationabout the client's needs and other important information.	1.1 Signed release of information forms are obtained.	1.1 Signed release of information is in the client's file.
1.2 Subrecipient will identify barriers to care and assist in resolving.	1.2 Subrecipient will document all barriers identified in referral process and actions taken to resolve them as case notes.	1.2 Client file reviewed at site visit.
1.3 Subrecipient will support clients through completion oflinkage referrals.	1.3 Subrecipient will utilize a tracking mechanism to monitor completion of all linkage referrals. 1.3 Subrecipient will document when a client declines to follow through on a referral.	1.3 Document follow-up activities and outcomes in the client's file. Reviewed at site visit.

Standard	Measure	Data Source
2.0 Referrals will consist of information to assist with identified medical care or service needs. A referral should include both contact so individual can follow-up as well as eligibility information.	2.0 Content of referrals include: • Eligibility requirements • Contact information, including website address • Description of service offered	2.0 Referral database documenting type and quantity of referrals.
2.1 Referrals should be appropriate to meet contact's needs and take cultural and linguistic context as well as individual preference into consideration.	2.1 Subrecipient program manual includes information on making referrals	2.1 Review of Program Manual
2.2 Subrecipient demonstrates active collaboration with other agencies to provide referrals to the full spectrum of HIV and other needed services.	2.2 Subrecipient will collaborate with other agencies and providers to provide effective, appropriate referrals.	2.2 Review of database to ensure it includes HIV resources and other needed services.
2.3 Referrals will be made to services critical to achieving optimal health and well-being. Referrals do not require follow-up although it may be offered.	2.3 Subrecipient will support the client to initiate referrals that were agreed upon by the client.	2.3 Subrecipient will document the type of referral made (i.e., food bank, testing site, etc.)

Standard	Measure	Data Source
Staff Qualifications and Training Supervisory Staff Standards		
3.0 Staff Qualifications and Training Supervisory Staff: • Bachelor's degree in human services field or 2 years direct service experience or combination of experience and education. • Experience working with diverse communities especially communities with HIV health disparities. • Knowledge of HIV prevention, care, and related issues. • Experience developing and maintaining resource directories. • Experience delivering community-based programs that engage targeted populations. **Direct Service Staff**: High School diploma or GED plus one or moreyears of social service experience or two years HIV prevention and/or care experience which may include lived experience. • Knowledge of HIV prevention and care resources • Ability to assess needs of clients or contacts and make appropriate linkage or referrals • Experience or training to meet needs of diverse populations and communities facing disparities.	3.0 Position description will show minimum and preferred qualifications. Staff will have regular skills training.	3.0 Review of position descriptions and staff resumes and training.

Standard	Measure	Data Source
4.0 Developing information and resources Subrecipients develop a resource database that includes: • Ryan White Parts A, B, C, D and F funded programs. • Health care clinics with expertise in providing health care to persons with HIV. This includes medical, mental, oral health and substance use care providers. • Range of resources that reduce barriers to care and/or provide basic needs. This includes housing, transportation, food resources, and other programs meeting social service needs, and are culturally, linguistically, and geographically diverse. • Subrecipient may create entire database or develop agreements (such as MinnesotaHelp.info) to link to existing databases to ensure comprehensive regional coverage.	4.0 Database entries include a description ofthe resource(s) available, eligibility criteria, contact information, costs if any and other pertinent details that assist individuals in connecting to the resource. 4.0 Data reviewed and updated annually by subrecipient.	4.0 Review at site visits.