REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES
STANDARDS OF CARE

DEFINITION

Referral for Health Care/Supportive Services is the act of directing a patient to a service in person or in writing, by telephone, or through another type of communication. These services are provided outside of outpatient/ambulatory medical care, medical case management, or non-medical case management services.

GOAL

In the Fort Worth Health Service Delivery Area, Referral for Health Care/ Supportive Services includes Patient Navigator (PN) programs. The goal of a PN is to remove barriers to effective care for HIV clients by coordinating services, thus increasing the client's chances for a healthy, quality life. A PN helps clients move through the complexities of the health care system and HIV Continuum of Care, assisting with improved quality treatment. The PN serves as a reliable ally to whom an HIV+ client can turn for advice and support. A PN understands the client's fears and hopes.

STANDARD OF CARE

HIRING STANDARDS

- All agencies should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for hiring Referral for Health Care/Supportive Services staff.
- All paid Patient Navigators must possess, at minimum, a high school diploma or equivalent.
- Patient Navigators should reflect the community that the program proposes to serve.

TRAINING STANDARDS

- All Patient Navigators should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for training.

**Note that training may be provided by the agency, an outside agency, or online. However, funded agencies must provide documentation that Patient Navigators completed the training in the prescribed time period. A list of online training resources is available from the Planning Council.*

JOB PERFORMANCE STANDARDS

- All Patient Navigators should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for job performance.
- Patient Navigators must attend case management staff meetings related to their clients.

- Patient Navigators are required to have a role on the Positive Voices Coalition (the steering committee for the PV input groups).
- Patient Navigators must attend at least one Positive Voices meeting per month (i.e., Positive Voices – Fort Worth, Voces Positivas).
- Patient Navigators must facilitate the removal of Barriers to Care for clients providing assistance with impediments that prevent client access to or retention in care, including, but not limited to:
    - Providing or arranging translation services;
    - Providing or arranging transportation to medical and social service appointments;
    - Providing or arranging assistance with obtaining medications;
    - Providing referrals and follow up for clients to necessary community resources; and
    - Providing or arranging client advocacy to assist clients with applications to third-party payer resources (e.g., Medicare/Medicaid, SSDI, insurance).
- Patient Navigators must attempt to return clients to care after an agency review of client attendance at medical and other appointments by contacting clients via telephone, postal mail, home visits, or any other means available which may include referral to outreach services.

<u>REPORTING STANDARDS</u>

- All Patient Navigators should abide by local requirements for reporting.

SPECIAL INSTRUCTIONS

1. Providers of this service will employ Patient Navigators, as defined by the Planning Council.
2. All Patient Navigator positions funded through the Administrative Agency must have at least 50% of their job specific to Patient Navigator functions.
3. Providers must include documented ongoing collaborations and referrals, and the ability to quantify successful referrals.
4. Clients presenting in a debilitating condition (e.g., substance abuse, mental health issues) must be referred, with documentation of the attempt to complete a referral, to an appropriate agency for a comprehensive assessment for possible treatment and care of the condition.
5. Providers must have updated and specific Memorandums of Understanding with other case management providers and those with whom referrals are needed.
6. Providers must have documentation of ongoing HIV-related education for staff (including administrative staff) funded through this program.