

<b>Non-medical Case Management (Service Linkage)</b>	<b>Pg</b>
<b>Service Category Definition Part A</b>	<b>1</b>
<b>Ryan White Part A/B 2011-2012 Standards of Care</b>	<b>8</b>
<b>Linkage to Care for HIV-Infected Heterosexual Men in the US - Clinical Infectious Diseases, 2011</b>	<b>31</b>

HRSA Service Category Title:	<b>Non-medical Case Management</b>
Local Service Category Title:	<p><b>A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA</b></p> <p><b>Not-In-Care PLWHA</b> are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months.</p> <p><b>Newly-Diagnosed PLWHA</b> are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care, newly-diagnosed and at risk Youth in the Houston EMA.</p> <p>*High-risk Youth are Youth who engage in behaviors that may place them at risk for HIV exposure.  *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months.  *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.</p>
Budget Type:	<b>Unit Cost</b>
Budget Requirements or Restrictions:	<b>Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.</b>
HRSA Service Category Definition:	<p><b>Case Management (non-Medical)</b> includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.</p> <p><b>Early intervention services (EIS)</b> include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.</p>
Local Service Category Definition:	<b>A. Service Linkage:</b> Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or

	<p><b><i>Not-In-Care</i></b> PLWHA who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> Providing Ryan White Program appropriate outreach and service linkage activities to high risk HIV-negative Youth and newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	<p><b>A. Service Linkage:</b> Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p><b>Service Linkage</b> is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women</p>

	<p>and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p> <p><b>B. Youth targeted Service Linkage, Care and Prevention:</b> Services will be available to eligible HIV-infected and at-risk HIV-negative Youth (ages 13 – 24) residing in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth at risk for, or living with, HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p> <p><b>Youth Targeted Service Linkage, Care and Prevention</b> is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.</p>
<p>Services to be Provided:</p>	<p><b>Goal (A): Service Linkage:</b> The expectation is that a single Service Linkage Worker FTE targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately <b>80</b> PLWH/A per year.</p> <p>The purpose of <b>Service Linkage</b> is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. <b>Service Linkage</b> is a working agreement between a client and a Community Case Manager (COCM) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of <b>Service Linkage</b> is to assist clients who do not require the intensity of <i>Clinical or Medical Case Management</i>, as determined by RWGA Quality Management guidelines. <b>Service Linkage</b> is primarily office-based and <b>includes the issuance of bus pass vouchers and gas cards per published guidelines.</b> Service Linkage targeted to Not-In-Care and/or Newly-</p>

	<p>Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing “hands-on” outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.</p> <p>In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 120 days of initiation of services as documented in the CPCDMS data system. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, <u>may receive ongoing service linkage services from provider</u> or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client.</p> <p><b>GOAL (B):</b> This effort will continue a program of <i>Service Linkage, Care and Prevention to Engage HIV Seropositive Youth</i>, specifically: Support of a project targeting youth (ages 13-24) with a focus on Youth of color. This service will support an innovative service model designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.</p>
Service Unit Definition(s):	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC’s approved <i>Financial Eligibility for Houston EMA Services</i> .
Client Eligibility:	<p>A. Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.</p> <p>B. High Risk HIV-negative, not-in-care and/or newly-diagnosed HIV-infected Youth residing in the Houston EMA.</p>
Agency Requirements:	<p><b>Service Linkage</b> services will comply with the HCPHES/RWGA published <b>Service Linkage</b> Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system.</p> <p><b>Service Linkage</b> targeted to High Risk HIV-negative, Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program</p>

	<p>reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.</p>
--	---

Staff Requirements:	<p>Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules.</p> <p><i>Must comply with applicable HCPHES/RWGA published Ryan White Part A/B Standards of Care:</i></p> <p><u>Minimum Qualifications:</u>  <b>Service Linkage Workers</b> must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA.</p> <p><u>Supervision:</u>  The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.</p>
Special Requirements:	<p><u>Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services.</u></p> <p>Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, semi-annual registration updates for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers and gas cards in accordance with HCPHES/RWGA policies and procedures.</p>

FY 2012 Service Category Definition - Ryan White Part A  
March 15, 2011

***FY 2012 RWPC “How to Best Meet the Need” Decision Process***

<b>Step in Process: Council</b>		Date: 06-09-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Steering Committee</b>		Date: 06-02-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: Quality Assurance Committee</b>		Date: 05-19-11
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
<b>Step in Process: HTBMTN Workgroup #1</b>		Date: 04-20-11
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**2011-2012 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE  
ACT PART A/B  
STANDARDS OF CARE FOR HIV SERVICES  
RYAN WHITE GRANT ADMINISTRATION SECTION  
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES (HCPHES)**

TABLE OF CONTENTS

Introduction.....	3
General Standards.....	5
Service Specific Standards	
Case Management (All Case Management Service Categories).....	18
Non-Medical Case Management (Service Linkage).....	21



## INTRODUCTION

According to the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 2008)<sup>1</sup>, a standard is a “statement that defines performance expectations, structures, or processes that must be in place for an organization to provide safe, high-quality care, treatment, and services”. Standards are developed by subject experts and are usually the minimal acceptable level of quality in service delivery. The Houston EMA Ryan White Grant Administration (RWGA) Standards of Care (SOCs) are based on multiple sources including RWGA on-site program monitoring results, consumer input, the US Public Health Services guidelines, Centers for Medicare and Medicaid Conditions of Participation (COP) for health care facilities, JCAHO accreditation standards, the Texas Administrative Code, Center for Substance Abuse and Treatment (CSAT) guidelines and other federal, state and local regulations.

### Purpose

The purpose of the Ryan White Part A/B SOCs is to determine the minimal acceptable levels of quality in service delivery and to provide a measurement of the effectiveness of services.

### Scope

The Houston EMA SOCs apply to Part A, Part B and State Services, funded HRSA defined core and support services including the following services in FY 2011-2012:

- Primary Medical Care
- Vision Care
- Medical Case Management
- Clinical Case Management
- Local AIDS Pharmaceutical Assistance Program (LPAP)
- Oral Health
- Health insurance
- Hospice Care
- Mental Health Services
- Substance Abuse services
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- Legal Services
- Medical Nutrition Therapy
- Non-Medical Case Management (Service Linkage)
- Food Bank
- Transportation
- Rehabilitation Services
- Linguistic Services

### Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make

---

<sup>1</sup> The Joint Commission on Accreditation of Healthcare Organization (2008). Comprehensive accreditation manual for ambulatory care; Glossary

applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

#### Organization of the SOCs

The standards cover all aspect of service delivery for all funded service categories. Some standards are consistent across all service categories and therefore are classified under general standards.

These include:

- Staff requirements, training and supervision
- Client rights and confidentiality
- Agency and staff licensure
- Emergency Management

The RWGA funds three case management models. Unique requirements for all three case management service categories have been classified under Service Specific SOCs “Case Management (All Service Categories)”. Specific service requirements have been discussed under each service category.

All new and/or revised standards are effective at the beginning of the fiscal year.

## GENERAL STANDARDS

	Standard	Measure
<b>1.0</b>	<b>Staff Requirements</b>	
1.1	<p><u>Staff Screening (Pre-Employment)</u>            Staff providing services to clients shall be screened for appropriateness by provider agency as follows:</p> <ul style="list-style-type: none"> <li>• Personal/Professional references</li> <li>• Personal interview</li> <li>• Written application</li> </ul> <p>Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Review of personnel and/or volunteer files indicates compliance</li> </ul>
1.2	<p><u>Initial Training: Staff/Volunteers</u>            Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire &amp; emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy). Initial training must be completed within 60 days of hire.</p>	<ul style="list-style-type: none"> <li>• Documentation of all training in personnel file.</li> <li>• Specific training requirements are specified in Agency Policy and Procedure</li> <li>• Materials for staff training and continuing education are on file</li> <li>• Staff interviews indicate compliance</li> </ul>
1.3	<p><u>Staff Performance Evaluation</u>            Agency will perform annual staff performance evaluation.</p>	<ul style="list-style-type: none"> <li>• Completed annual performance evaluation kept in employee's file</li> </ul>
1.4	<p><u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u>            All staff must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.</p>	<ul style="list-style-type: none"> <li>• Documentation of training is maintained by the agency in the personnel file</li> </ul>
1.5	<p><u>Staff education on eligibility determination and fee schedule</u>            Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for all applicable staff annually.</p>	<p>Documentation of training in employee's record</p>

<b>2.0</b>	<b>Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.</b>	
2.1	<u>Service Evaluation</u> Agency has a process in place for the evaluation of client services.	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Staff interviews indicate compliance.</li> </ul>
2.2	<u>Subcontractor Monitoring</u> Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: <ul style="list-style-type: none"> <li>• Fiscal monitoring</li> <li>• Program</li> <li>• Quality of care</li> <li>• Compliance with guidelines and standards</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of subcontractor monitoring</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>
2.3	<u>Staff Guidelines</u> Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, job descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights.	<ul style="list-style-type: none"> <li>• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures</li> </ul>
2.4	<u>Work Conditions</u> Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	<ul style="list-style-type: none"> <li>• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply</li> <li>• Staff interviews indicate compliance</li> </ul>
2.5	<u>Staff Supervision</u> Staff services are supervised by a paid coordinator or manager.	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>
2.6	<u>Professional Behavior</u> Staff must comply with written standards of professional behavior.	<ul style="list-style-type: none"> <li>• Staff guidelines include standards of professional behavior</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Review of personnel files indicates compliance</li> <li>• Review of agency’s complaint and grievance files</li> </ul>

2.7	<p><u>Communication</u></p> <p>There are procedures in place regarding regular communication with staff about the program and general agency issues.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of regular staff meetings</li> <li>• Staff interviews indicate compliance</li> </ul>
2.8	<p><u>Accountability</u></p> <p>There is a system in place to document staff work time.</p>	<ul style="list-style-type: none"> <li>• Staff time sheets or other documentation indicate compliance</li> </ul>
2.9	<p><u>Staff Availability</u></p> <p>Staffs are present to answer incoming calls during agency's normal operating hours.</p>	<ul style="list-style-type: none"> <li>• Published documentation of agency operating hours</li> <li>• Staff time sheets or other documentation indicate compliance</li> </ul>
<b>3.0</b>	<b>Clients Rights and Responsibilities</b>	
3.1	<p><u>Clients Rights and Responsibilities</u></p> <p>Agency has a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. Agency will provide client with written copy of client rights and responsibilities, including:</p> <ul style="list-style-type: none"> <li>• Informed consent</li> <li>• Confidentiality</li> <li>• Grievance procedures</li> <li>• Duty to warn or report certain behaviors</li> <li>• Scope of service</li> <li>• Criteria for end of services</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation in client's record</li> </ul>
3.2	<p><u>Confidentiality</u></p> <p>Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency.</p> <p>There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Clients interview indicates compliance</li> <li>• Agency's structural layout and information management indicates compliance</li> <li>• Signed confidentiality statement in each employee's personnel file</li> </ul>
3.3	<p><u>Consents</u></p>	<ul style="list-style-type: none"> <li>• Agency Policy and Procedure and signed and dated consent</li> </ul>

	All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	forms in client record
3.4	<p><u>Up to date Release of Information</u></p> <p>Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain:</p> <ul style="list-style-type: none"> <li>• Name of the person or entity permitted to make the disclosure</li> <li>• Name of the client</li> <li>• The purpose of the disclosure</li> <li>• The types of information to be disclosed</li> <li>• Entities to disclose to</li> <li>• Date on which the consent is signed</li> <li>• The expiration date of client authorization (or expiration event) no longer than two years</li> <li>• Signature of the client/or parent, guardian or person authorized to sign in lieu of the client.</li> <li>• Description of the <i>Release of Information</i>, its components, and ways the client can nullify it</li> </ul> <p>Released/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.</p>	<ul style="list-style-type: none"> <li>• Current Release of Information form with all the required elements signed by client or authorized person in client's record</li> </ul>
3.5	<p><u>Grievance Procedure</u></p> <p>Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client.</p> <p>Grievance procedure includes but is not limited to:</p>	<ul style="list-style-type: none"> <li>• Signed receipt of agency Grievance Procedure, filed in client chart</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>

	<ul style="list-style-type: none"> <li>• to whom complaints can be made</li> <li>• steps necessary to complain</li> <li>• form of grievance, if any</li> <li>• time lines and steps taken by the agency to resolve the grievance</li> <li>• documentation by the agency of the process</li> <li>• confidentiality of grievance</li> <li>• addresses and phone numbers of licensing authorities and funding sources</li> </ul>	
3.6	<p><u>Conditions Under Which Discharge/Closure May Occur</u></p> <p>A client may be discharge from Ryan White funded services for the following reasons.</p> <ul style="list-style-type: none"> <li>• Death of the client</li> <li>• At the client's or legal guardian request</li> <li>• Changes in client's need which indicates services from another agency</li> <li>• Fraudulent claims or documentation about HIV diagnosis by the client</li> <li>• Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues.</li> <li>• Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit).</li> </ul> <p>Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc).</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the Centralized Patient Care Data Management System</li> <li>• A copy of written notice and a certified mail receipt for involuntary termination</li> </ul>
3.7	<p><u>Client Closure</u></p> <p>A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including:</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the Centralized Patient Care Data Management System</li> </ul>

	<ul style="list-style-type: none"> <li>• Date and reason for discharge/closure</li> <li>• Summary of all services received by the client and the client's response to services</li> </ul> <p>Referrals made and/or instructions given to the individual at discharge (when applicable)</p>	
3.8	<p><u>Client Feedback</u></p> <p>In addition to the RWGA standardized client satisfaction survey conducted annually, Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts must include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB).</p>	<ul style="list-style-type: none"> <li>• Documentation of clients' evaluation of services is maintained</li> <li>• Documentation of CAB and public meeting minutes</li> <li>• Documentation of existence and appropriateness of a suggestion box or other client input mechanism</li> <li>• Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually</li> </ul>
3.9	<p><u>Patient Safety (Core Services Only)</u></p> <p>Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation <i>for Ambulatory Care</i> (<a href="http://www.jointcommission.org">www.jointcommission.org</a>) to ensure patients' safety. The NPSG to be addressed include the following as applicable:</p> <ul style="list-style-type: none"> <li>• "Improve the accuracy of patient identification</li> <li>• Improve the safety of using medications</li> <li>• Reduce the risk of healthcare-associated infections</li> <li>• Accurately and completely reconcile medications across the continuum of care</li> <li>• Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (<a href="http://www.jointcommission.org">www.jointcommission.org</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
3.10	<p><u>Client Files</u></p>	<ul style="list-style-type: none"> <li>• Review of agency's policy and procedure for records</li> </ul>

	Provider shall maintain all client files.	administration indicates compliance
<b>4.0</b>	<b>Accessibility</b>	
4.1	<p><u>Cultural Competence</u></p> <p>Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals.</p>	<ul style="list-style-type: none"> <li>• Agency has procedures for obtaining translation services</li> <li>• Client satisfaction survey indicates compliance</li> <li>• Policies and procedures demonstrate commitment to the community and culture of the clients</li> <li>• Availability of interpretive services, bilingual staff, and staff trained in cultural competence</li> <li>• Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record</li> </ul>
4.2	<p><u>Client Education</u></p> <p>Agency demonstrates capacity for client education and provision of Information on community resources</p>	<ul style="list-style-type: none"> <li>• Availability of the blue book and other educational materials</li> <li>• Documentation of educational needs assessment and client education in clients' records</li> </ul>
4.3	<p><u>Special Service Needs</u></p> <p>Agency demonstrates a commitment to assisting individuals with special needs</p>	<ul style="list-style-type: none"> <li>• Agency compliance with the Americans with Disabilities Act (ADA).</li> <li>• Review of Policies and Procedures indicates compliance</li> <li>• Environmental Review shows a facility that is handicapped accessible</li> </ul>
4.4	<p><u>Provision of Services for low-Income Individuals</u></p> <p>Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.</p>	<ul style="list-style-type: none"> <li>• Facility is accessible by public transportation</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
4.5	<p><u>Proof of HIV Diagnosis</u></p> <p>Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services.</p> <p>An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a</p>	<ul style="list-style-type: none"> <li>• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03</li> </ul>

	reasonable amount of certainty.	
4.6	<p><u>Provision of Services Regardless of Current or Past Health Condition</u></p> <p>Agency must have Policies and Procedures in place to ensure that HIV+ clients are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.</p>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures indicates compliance</li> <li>• A file containing information on clients who have been refused services and the reasons for refusal</li> </ul>
4.7	<p><u>Client Eligibility</u></p> <p>In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> <li>• HIV+</li> <li>• Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.)</li> <li>• Income no greater than 300% of the Federal Poverty level (unless otherwise indicated)</li> <li>• Proof of identification</li> <li>• Ineligibility for third party reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> <li>• Documentation of ineligibility for third party reimbursement</li> <li>• Documentation of screening for Third Party Payers in accordance with TRG Policy SG-06 Documentation of Third Party Payer Eligibility or RWGA site visit guidelines</li> </ul>
4.8	<p><u>Re-evaluation of Client Eligibility</u></p> <p>Agency conducts six (6) month re-evaluations of eligibility for all clients. At a minimum, agency confirms renewed eligibility with the CPCDMS and re-screens, as appropriate, for third-party payers. Third party payors include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. Agency must ensure that Ryan White is the Payor of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payor of last resort requirement</p>	<ul style="list-style-type: none"> <li>• Client file contains documentation of re-evaluation of client residence, income and rescreening for third party payers at least every six (6) months</li> <li>• Review of Policies and Procedures indicates compliance</li> <li>• Information in client's files that includes proof of screening for insurance coverage</li> </ul>

<p>4.9</p>	<p><u>Charges for Services</u>            Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL) is <math>\leq</math> 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below:</p> <ul style="list-style-type: none"> <li>• 101%-200% of FPL---5% or less of GIL</li> <li>• 201%-300% of FPL---7% or less of GIL</li> <li>• &gt;300% of FPL -----10% or less of GIL</li> </ul> <p>Additionally, agency must implement the following:</p> <ul style="list-style-type: none"> <li>• Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.)</li> <li>• Tracking of charges</li> <li>• A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year.</li> <li>• <u>Documentation of fees</u></li> </ul>	<ul style="list-style-type: none"> <li>• Review of Policies and Procedures indicates compliance</li> <li>• Review of system for tracking patient charges and payments indicate compliance</li> <li>• Review of charges and payments in client records indicate compliance with annual cap</li> <li>• Sliding fee application forms on client record is consistent with Federal guidelines</li> </ul>
<p>4.10</p>	<p><u>Information on Program and Eligibility/Sliding Fee Schedule</u>            Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update.            Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements.            Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to</p>	<ul style="list-style-type: none"> <li>• Agency has a written substantiated annual plan to targeted populations</li> <li>• Zip code data show provider is reaching clients throughout service area (as applicable to specific service category).</li> <li>• Agency file containing informational materials about agency services and eligibility requirements including the following:              Brochures              Newsletters              Posters              Community bulletins              any other types of promotional materials</li> <li>• Signed receipt for client education/ information regarding</li> </ul>

	program or agency.	eligibility and sliding fees on client record
4.11	<p><u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.</p>	<ul style="list-style-type: none"> <li>• Documentation of client referral is present in client file</li> </ul>
4.12	<p><u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes;</p> <p>The Agency will notify The Resource Group (TRG) or RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Subgrantee's plan must address:</p> <ul style="list-style-type: none"> <li>• Action steps to be taken by Subgrantee to resolve the service shortfall; and</li> <li>• Projected date that services will resume.</li> </ul> <p>The Agency will report to TRG or RWGA in writing on a monthly basis while a client wait list is required with the following information:</p> <ul style="list-style-type: none"> <li>• Number of clients on the wait list.</li> <li>• Progress toward completing the plan for resumption of</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of compliance with TRG's Policy SG-19 Client Wait Lists</li> <li>• Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted</li> </ul>

	<p>service.</p> <ul style="list-style-type: none"> <li>• A revised plan for resumption of service, if necessary.</li> </ul>	
4.13	<p><u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. When necessary, client is provided alternatives to office visits, such as conducting business by mail or providing home visits. Agency has established procedures for communicating with people with hearing impairments.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
<b>5.0</b>	<b>Quality Management</b>	
5.1	<p><u>Continuous Quality Improvement (CQI)</u> Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum:</p> <ul style="list-style-type: none"> <li>• The Agency's QM Plan</li> <li>• Meeting agendas and/or notes (if applicable)</li> <li>• Project specific CQI Plans</li> <li>• Root Cause Analysis &amp; Improvement Plans</li> <li>• Data collection methods and analysis</li> <li>• Work products</li> <li>• QM program evaluation</li> <li>• Materials necessary for QM activities</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Up to date QM Manual</li> </ul>
5.2	<p><u>Data Collection and Analysis</u> Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.</p>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Up to date QM Manual</li> <li>• Supervisors log on record reviews signed and dated</li> </ul>

<b>6.0</b>	<b>Point Of Entry Agreements</b>	
6.1	<u>Points of Entry (Core Services Only)</u> Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	<ul style="list-style-type: none"> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> <li>• Documentation of formal agreements with appropriate Points of Entry</li> <li>• Documentation of referrals and their follow-up</li> </ul>
<b>7.0</b>	<b>Emergency Management</b>	
7.1	<u>Emergency Preparedness</u> Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission’s regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize “all hazard approach” (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	<ul style="list-style-type: none"> <li>• Emergency Preparedness Plan</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>
7.2	<u>Emergency Management Training</u> In accordance with the Department of Human Services recommendations, all agency staff must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: <ul style="list-style-type: none"> <li>• IS -100.HC – Introduction to the Incident command system for healthcare/hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of all training including certificate of completion in personnel file</li> </ul>

	<ul style="list-style-type: none"> <li>• IS-200.HC- Applying ICS to Healthcare organization</li> <li>• IS-700.A-National Incident Management System (NIMS) Introduction</li> <li>• IS-800.B National Response Framework (management)</li> </ul> <p>The above courses may be accessed at:<a href="http://www.training.fema.gov">www.training.fema.gov</a>. Agencies providing support services only may complete alternate courses listed for the above areas All new employees are required to complete the courses within 90 days of hire. Other staff must complete the tracks by June 30, 2011.</p>	
7.3	<p><u>Emergency Preparedness Plan</u> The emergency preparedness plan shall address the six critical areas for emergency management including</p> <ul style="list-style-type: none"> <li>• Communication pathways</li> <li>• Essential resources and assets</li> <li>• patients' safety and security</li> <li>• staff responsibilities</li> <li>• Supply of key utilities such as portable water and electricity</li> <li>• Patient clinical and support activities during emergency situations. (<a href="http://www.jointcommission.org">www.jointcommission.org</a>)</li> </ul>	<ul style="list-style-type: none"> <li>• Emergency Preparedness Plan</li> </ul>
7.4	<p><u>Emergency Management Drills</u> Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.</p>	<ul style="list-style-type: none"> <li>• Emergency Management Plan</li> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> </ul>
<b>8.0</b>	<b>Building Safety</b>	
8.1	<p><u>Required Permits</u> All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.</p>	<ul style="list-style-type: none"> <li>• Current required permits on file</li> </ul>

## SERVICE SPECIFIC STANDARDS OF CARE

**Case Management (All Case Management Categories)**

Case management services in HIV care facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of PLWHA. It also involves client assessment to determine client's needs and the development of individualized service plans in collaboration with the client to mitigate clients' needs. Ryan White Grant Administration funds three case management models i.e. one psychosocial and two clinical/medical models depending on the type of ambulatory service within which the case management service is located. The scope of these three case management models namely, Non-Medical, Clinical and Medical case management services are based on Ryan White HIV/AIDS Treatment Modernization Act of 2006 (HRSA)<sup>2</sup> definition for non-medical and medical case management services. Other resources utilized include the current *National Association of Social Workers (NASW) Standards for Social Work Case Management*<sup>3</sup>. Specific requirements for each of the models are discussed under each case management service category.

<b>1.0</b>	<b>Staff Training</b>	
1.1	<u>Required Meetings</u> Case managers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by the designated RWGA provider.  Case Managers will attend the "Joint Prevention and Care Coordination Meeting" held annually and facilitated by the designated RWGA provider.	<ul style="list-style-type: none"> <li>Agency will maintain verification of attendance</li> </ul>
1.2	<u>Required Training for New Employees</u> Within the first six (6) months of employment in the case management system, case managers will complete at least eight (8) hours medical, at least eight (8) hours psychosocial, at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by the designated RWGA Provider. Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the	<ul style="list-style-type: none"> <li>Certificates of completion for applicable trainings in the case manager's file</li> <li>Sign-in sheets for agency based trainings maintained by Agency</li> <li>RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum</li> </ul>

<sup>2</sup> US Department of Health and Human Services, Health Resources and Services Administration HIV/AIDS Bureau (2009). Ryan White HIV/AIDS Treatment Modernization Act of 2006: Definitions for eligible services

<sup>3</sup> National Association of Social Workers (1992). NASW standards for social work case management. Retrieved 02/9/2009 from [www.socialworkers.org/practice/standards/sw\\_case\\_mgmt.asp](http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp)

	first year training for case management staff.	
1.3	<p><u>Case Management Supervisor Peer-led Training</u></p> <p>Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by the designated Part A/B provider.</p>	<ul style="list-style-type: none"> <li>• Review of attendance sign-in sheet indicates compliance</li> </ul>
1.4	<p><u>Child Abuse Screening, Documenting and Reporting Training</u></p> <p>Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.</p>	<ul style="list-style-type: none"> <li>• Documentation of staff training</li> </ul>
<b>2.0</b>	<b>Timeliness of Services</b>	
2.1	<p><u>Initial Case Management Contact</u></p> <p>Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>
2.2	<p><u>Intake</u></p> <p>In addition to the general intake requirements, a thorough intake is completed at the earliest convenience of the client, but no later than two (2) weeks after initial contact.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>
2.3	<p><u>Acuity</u></p> <p>The case manager should use an acuity scale or other standardized system as a measurement tool to determine client needs (applies to TDSHS funded case managers only).</p>	<ul style="list-style-type: none"> <li>• Completed acuity scale in client's records</li> </ul>
2.4	<p><u>Progress Notes</u></p> <p>All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are</p>	<ul style="list-style-type: none"> <li>• Legible, signed and dated documentation in client record.</li> <li>• Documentation of time expended with or on</li> </ul>

	documented in the client record within 72 hours of their occurrence.	behalf of patient in progress notes
2.5	<p><u>Client Referral and Tracking</u></p> <p>Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS).</p> <p>The Case Manager will:</p> <ul style="list-style-type: none"> <li>• Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager</li> <li>• Work with the Client to determine barriers to referrals and facilitate access to referrals</li> <li>• Utilize a tracking mechanism to monitor completion of all case management referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Documentation of follow-up tracking activities in clients records</li> <li>• A current list of agencies that provide services including availability of the Blue Book</li> </ul>
2.6	<p><u>Client Transfers between Agencies: Open or Closed less than One Year</u></p> <p>The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and submitted to RWGA by the receiving agency.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>
2.7	<p><u>Caseload</u></p> <p>Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.</p>	<ul style="list-style-type: none"> <li>• Review of the agency's policies and procedures for Staffing ratios</li> </ul>

**Non-Medical Case Management Services (Service Linkage Worker)**

Non-medical case management services (Service Linkage Worker (SLW) is co-located in ambulatory/outpatient medical care centers. HRSA defines Non-Medical case management services as the “provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services” and does not include coordination and follow-up of medical treatment. The Ryan White Part A/B SLW provides services to clients who do not require intensive case management services and these include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients to develop and utilize independent living skills and strategies.

<p>1.1</p>	<p><u>Minimum Qualifications</u>                  Service Linkage Worker – unlicensed community case manager                  Service linkage workers must have a bachelor’s degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the bachelor’s degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1 year paid work experience with PLWHA.                  Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish.                  Agency will provide Service Linkage Worker a written job description upon hiring.</p>	<ul style="list-style-type: none"> <li>• A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker’s file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.</li> </ul>
<p>1.2</p>	<p><u>Ongoing Education/Training for Service Linkage Workers</u>                  After the first year of employment in the case management system service linkage worker will obtain a minimum of fifteen (15) hours per year additional education and/or training (including two (2) hours review of community resources) offered by the designated RW Part A/B Provider or may obtain comparable training from other sources. The topics must conform to the list of topics required for the advanced training track. If the training is obtained outside the RW Part A/B Provider, the agency will be responsible for the cost through their unit cost contract. Any training to be paid through the RW Part A/B contract must be pre-approved by RWGA.</p>	<ul style="list-style-type: none"> <li>• Attendance sign-in sheet and/or certificates of completion are maintained by the agency</li> </ul>

2.0	<b>Timeliness of Services/Documentation</b>	
2.1	<p><u>Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed</u></p> <p>In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services:</p> <ul style="list-style-type: none"> <li>• HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or</li> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care services as documented by the CPCDMS, or</li> <li>• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and income in the client record</li> <li>• Documentation of “not in care” status through the CPCDMS</li> </ul>
2.2	<p><u>Service Linkage Worker Assessment</u></p> <p>Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment.</p> <p>The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. <b><u>Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status. Clients issued a value-based bus pass must be maintained on Open Status and be reassessed per SOC.</u></b></p>	<ul style="list-style-type: none"> <li>• Documentation in client record on the brief assessment form, signed and dated</li> <li>• A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate</li> </ul>
2.3	<p><u>Service Linkage Worker Reassessment</u></p> <p>Clients on <b><u>open status</u></b> will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved</p>	<ul style="list-style-type: none"> <li>• Documentation in RWGA approved client reassessment form or agency’s equivalent form, signed and dated</li> </ul>

	reassessment form as applicable must be utilized.	
2.4	<p><u>Transfer of Not-in-Care and Newly Diagnosed Clients</u></p> <p>Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 120 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program within 120 days of the initiation of services.</p>	<ul style="list-style-type: none"> <li>• Documentation in client record and in the CPCDMS</li> </ul>
<b>3.0</b>	<b>Supervision and Caseload</b>	
3.1	<p><u>Service Linkage Worker Supervision</u></p> <p>A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master’s level health professional. ) At least one (1) hour of supervision must be individual supervision.</p> <p>Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.</p>	<ul style="list-style-type: none"> <li>• Documentation in supervision notes, which must include: <ul style="list-style-type: none"> <li>➢ date</li> <li>➢ name(s) of case manager(s) present</li> <li>➢ topic(s) covered and/or client(s) reviewed</li> <li>➢ plan(s) of action</li> <li>➢ supervisor’s signature</li> </ul> </li> <li>• Supervision notes are never maintained in the client record</li> </ul>
3.2	<p><u>Caseload Coverage – Service Linkage Workers</u></p> <p>Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client’s “assigned” case manager.</p>	<ul style="list-style-type: none"> <li>• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System</li> </ul>
3.3	<p><u>Case Reviews – Service Linkage Workers.</u></p> <p>Supervisor reviews each open case with the service linkage worker at least once ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.</p>	<ul style="list-style-type: none"> <li>• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW</li> </ul>

# Linkage to Care for HIV-Infected Heterosexual Men in the United States

Nickolas D. Zaller,<sup>1,2</sup> Jeannia J. Fu,<sup>2</sup> Amy Nunn,<sup>1,2</sup> and Curt G. Beckwith<sup>1,2</sup>

<sup>1</sup>Alpert Medical School, Brown University, and <sup>2</sup>Division of Infectious Diseases, Miriam Hospital, Providence, Rhode Island

**In the United States, the human immunodeficiency virus (HIV) epidemic among heterosexual men disproportionately affects individuals involved with the criminal justice system, injection drug and other substance users, and racial and ethnic minorities. These overlapping populations confront similar social and structural disparities that contribute to HIV risk and limit access to HIV testing, treatment, and care. In this review, we discuss barriers to linkage to comprehensive HIV care for specific subpopulations of heterosexual men and examine approaches for enhancing linkage to care for this diverse population.**

In 1997, 78% of all AIDS cases in the United States were among men [1]. A decade later, the human immunodeficiency virus (HIV)/AIDS epidemic remains disproportionately concentrated among men, who represent nearly three-fourths of all HIV/AIDS cases and new HIV infections among adults and adolescents [2]. HIV-infected men are also more likely to receive a diagnosis late in the course of infection [3] and have lower CD4 cell counts when care is initiated [4]. In 2007, 46% of men infected through heterosexual contact progressed to AIDS within 12 months, compared with 36% of the total HIV-infected population [2]. Significant racial and ethnic disparities in HIV infection persist. In 2007, black and Hispanic men comprised 57% of all HIV/AIDS diagnoses among men, and black men experienced the highest rate of new HIV infections of any demographic group (115.7/100,000 population) [2]. Racial and ethnic minorities are also disproportionately represented among late diagnoses and are significantly more likely to experience delayed linkage to care [5–11].

Modes of HIV transmission among men have changed during the last decade [1, 2]. Male-to-male sexual contact remains the primary mode of transmission among men in the United States; however, 16% of HIV-positive men were infected through heterosexual sex and 12% through injection drug use (IDU) in 2007 [2]. Whereas the number of new HIV/AIDS cases among men resulting from IDU has declined during the past 2 decades and stabilized since 2004, infections attributable to heterosexual sex have increased [2]. Increasing rates of heterosexual HIV transmission underscore the potential for a more generalized heterosexual HIV epidemic, and studies in Washington, DC, and Baltimore, Maryland, have identified this trajectory in marginalized urban communities [12, 13]. Figure 1 depicts the proportion of heterosexual men among the total number of persons with HIV infection in the United States between 2000 and 2007 [2, 14–20].

In the United States, the HIV epidemic among heterosexual men disproportionately affects individuals involved with the criminal justice system, injection drug users (IDUs), other substance users, and racial and ethnic minorities. These overlapping populations confront similar social and structural disparities that contribute to HIV risk and limit access to HIV testing, treatment, and care. In describing these disparities and risks, clinicians and researchers need to be particularly cautious about protecting sensitive health information, such as drug use and sexual risk-taking behaviors. Some

Correspondence: Nickolas D. Zaller, MD, 164 Summit Ave, Providence, RI, 02909 (nzaller@lifespan.org).

**Clinical Infectious Diseases** 2011;52(S2):S223–S230

© The Author 2011. Published by Oxford University Press on behalf of the Infectious Diseases Society of America. All rights reserved. For Permissions, please e-mail: journals.permissions@oup.com.

1058-4838/2011/52S2-0001\$37.00

DOI: 10.1093/cid/ciq046

**Table 1. Linkage to Care among Heterosexual Men with Human Immunodeficiency Virus Infection: Barriers and Facilitators**

Barriers or Challenges	Successful Strategies
Incarceration	Communication between correctional and community providers; comprehensive discharge planning and case management; availability of substance use treatment within and outside correctional facilities
Substance dependence	Directly administered antiretroviral therapy; integrated opiate replacement and antiretroviral therapy; case management; integration or colocation of medical care and supportive services
Stigma and distrust	Peer engagement and outreach; sustained engagement with target population
Structural or environmental barriers	Case management and colocation of services; linkage to health insurance; access to stable housing; job training and placement programs

researchers have used peer-based interventions and employed research staff of the same race and/or cultural background as the study participants to enhance participants' comfort with the research and to bolster the quality of data collected [21, 22]. Other studies have used technology such as audio computer-assisted self-interviews to improve rates of reporting of sensitive behaviors and to reduce socially desirable responding [23–26]. In this review, we discuss barriers to linking specific subpopulations of heterosexual men to comprehensive HIV care and examine approaches for enhancing the linkage to care for this diverse population.

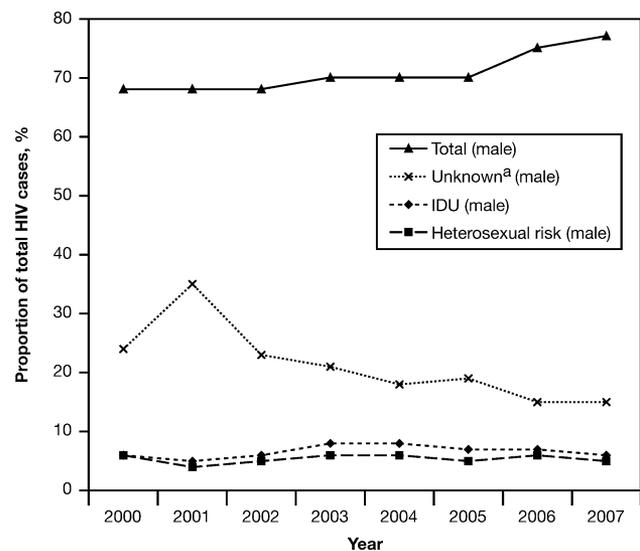
## EMERGING SUBPOPULATIONS AT RISK

### IDU Populations

During the past 2 decades, there has been a significant decline in IDU-related HIV infections [27–29], probably in part because of increases in HIV prevention programs targeted to IDUs, including syringe exchange programs [30, 31]. Despite these declines, IDU-related HIV transmission continues to affect racial and ethnic minorities at disproportionate rates, particularly African American men [32]. Recent data from the Centers for Disease Control and Prevention indicate that between 2004 and 2007, 62% of incident IDU-associated HIV infections were among men and 58% of those infected through IDU were black [32]. In addition, 40% of HIV-infected IDUs received late HIV diagnoses, defined as receiving an AIDS diagnosis within 12 months of HIV diagnosis [32]. Among African Americans in high-risk communities in Houston, Texas, Risser et al found that individuals reporting both IDU and heterosexual anal intercourse had 6.2 times the odds of being HIV infected [33]. In a sample of 3555 drug users and neighborhood controls, McCoy et al found that IDUs and those reporting both IDU and crack cocaine smoking were 9.8 and 5.27 times, respectively, more likely to be HIV infected [34]. These findings demonstrate the need for coordinated efforts between researchers, policymakers, and outreach and community-based organizations to address late HIV diagnoses among IDUs and to target interventions to the needs of specific IDU subpopulations.

### Nonparenteral Substance Users

Despite the overall decline in IDU-related HIV infections, the association between nonparenteral substance use and HIV infection has been increasingly demonstrated. In some areas of the United States, HIV prevalence among crack cocaine smokers may be comparable to or greater than among IDUs [35]. Booth et al found that crack cocaine smokers and crack cocaine-smoking IDUs were more likely to report having multiple sexual partners and exchanging sex for drugs or money than those who only injected [36]. McCoy et al found that, compared with neighborhood controls, crack cocaine smokers were 2.2 times more likely to be infected with HIV [34]. Adimora et al also found a statistically significant association between sexual concurrency and crack cocaine smoking in a sample of rural African Americans with recent heterosexually acquired HIV infection [37]. Alcohol use has also been shown to be an important mediator of high-risk sexual behavior among men [38, 39], with



**Figure 1.** Estimated proportion of human immunodeficiency virus (HIV) infection among males in the United States, by transmission category, 2000–2007. Source: Centers for Disease Control and Prevention annual HIV/AIDS surveillance reports [2,14–20]. <sup>a</sup>Unknown indicates other or risk factor not reported or identified.

additional studies finding strong associations between alcohol use and HIV incidence [40, 41]. Methamphetamine use is yet another emerging risk factor for HIV infection among heterosexual men [42, 43].

### Men Who Have Sex With Men and Women

Understanding risk factors among men who have sex with men and women (MSMW) and adapting effective prevention interventions should be priorities, given the potential of MSMW to bridge the epidemics between sexes. Lichtenstein found that bisexual activity is often unprotected among black MSMW [44], and Williams et al identified high rates of IDU and crack use among MSMW [45]. In a sample of mostly low-income, unemployed, minority MSMW, Gorbach et al found that sexual and drug use networks were highly interconnected [46].

### Foreign-born Populations

Another characteristic of the changing HIV epidemic among heterosexual males in the United States is the increasing number of HIV-infected persons who are foreign born [47]. This includes legal and illegal immigrants as well as refugees and asylum seekers. The regulatory change in 2009 that removed HIV infection from the list of communicable diseases of public health significance among foreign immigrants may affect the proportion of foreign-born HIV-infected persons in the United States in the coming years [48]. Before this change, HIV-infected immigrants were inadmissible to the country without a government waiver. Heterosexual risk is the predominant mode of HIV transmission among many foreign-born populations [49, 50]; however, relatively little is known about the epidemiology of HIV infection in these populations and the extent to which these individuals engage in HIV care after arrival in the United States.

## LINKAGE TO CARE

### Correctional Populations

Large numbers of HIV-infected individuals pass through correctional facilities each year. In 2006, 1 in 7 HIV-positive individuals in the United States were incarcerated [51]. Access and adherence to antiretroviral treatment can often be most difficult in the period immediately after release from incarceration. Recently released individuals are at elevated risk for relapse to drug use and sexual and drug-related risk behaviors [52–58] and have difficulty securing stable housing and employment [59–61]. These stressors during community reentry may disrupt engagement in care and lead to worsened virologic outcomes as well as increase the risk of secondary HIV transmission [62–64]. Newly released African American and Latino inmates in particular have difficulty accessing antiretroviral treatment (ART) in the community [65].

The majority of correctional facilities provide some type of discharge planning for HIV-positive inmates (T. M. Hammett,

S. Kennedy, S. Kuck, unpublished data, 2007), and studies have found that inmates who receive such assistance are more likely to engage in HIV treatment and care in the community [61, 66]. However, Grinstead et al found that staff responsible for discharge planning may not be informed of inmates' HIV status or have knowledge of HIV-related services in the community [67], indicating that education of discharge planning staff and coordination with community providers could probably be improved.

Because recently released HIV-infected inmates confront a multitude of challenges during community reentry, initiating and remaining engaged in community-based care often requires intensive and sustained assistance that addresses barriers such as substance dependence, mental illness, unstable housing, unemployment, and lack of health insurance. Intensive case management can be successful in engaging recently released HIV-infected prisoners into medical care and providing linkage to social services [63]. Newly released HIV-infected individuals are also more likely to fill a prescription for ART within 10, 30, or 60 days of release if they receive assistance from a community caseworker in completing the AIDS Drug Assistance Program application [65]. However, fewer than half of state and federal correctional facilities and only 39% of city and county systems provide referrals to case management services for HIV-infected inmates during discharge planning (T. M. Hammett, S. Kennedy, S. Kuck, unpublished data, 2007). Organized discharge planning and intensive case management are critical to facilitating successful linkage to and retention in care within this population and should be implemented on a wide scale.

### Substance-Using Populations

Substance use frequently undermines the medical management of HIV among HIV-infected substance users [68], who are also more likely to experience high levels of socioeconomic instability and have limited health care access and utilization [68–70]. In a systematic review of 41 studies examining the relationship between substance use and adherence to ART, Malta et al found that active substance use was widely associated with poor ART adherence [71]. In turn, these associations may create reluctance among physicians to initiate combination ART in active substance users [72].

Involvement with the criminal justice system further complicates the provision of HIV care for substance users. Kerr et al found that incarceration was the strongest predictor for discontinuation of ART among HIV-infected IDUs, with individuals reporting recent incarceration having 5-fold higher odds of discontinuing highly active ART (95% confidence interval [CI], 1.2–18.7) [73]. Furthermore, because of the limited provision of substance-dependence treatment such as opiate replacement therapy (ORT) in correctional facilities [74], substance-dependent individuals undergoing treatment with

buprenorphine or methadone in the community may not be able to continue treatment while incarcerated [75]. As a result, they may undergo withdrawal and be less inclined to reinstate treatment after release [75], which may increase their risk of relapse to drug use and significantly affect their ability to engage in HIV treatment and care. Recently, studies in several cities have demonstrated the feasibility and effectiveness of linking prisoners to ART during incarceration and after release [76–84].

Despite the challenges to engaging and retaining this population in care, a number of different treatment interventions targeted to HIV-infected substance users have achieved favorable clinical outcomes. Smith-Rohrberg et al conducted a randomized, controlled trial of directly administered ART for IDUs and found improved virologic and immunologic outcomes as well as improved adherence [85]. Integrating substance dependence and HIV treatment is an approach to engaging substance users in care that directly addresses substance use and its associated complications. The efficacy of integrating ART and HIV treatment has been increasingly examined and models that integrate treatment with buprenorphine-naloxone into HIV primary care have recently been successfully piloted [68, 86–89]. Medication-assisted treatment is also available for individuals dependent on cocaine, methamphetamine, or alcohol, although more work is needed to explore the potential for integrating these therapies with ART and HIV care [90].

Case management and colocation of services can also enhance linkage to care for substance users [91], although interventions using case management alone may be less effective than direct linkage to substance-dependence treatment in this population [92]. In their study, Smith-Rohrberg et al assessed the impact of colocated medical, case management, and referral to substance abuse services among drug users undergoing directly administered ART and found that greater utilization of onsite medical and case management services was independently associated with improved virologic outcomes [85]. The impact of case management on engagement and retention in care has also been demonstrated among substance-using homeless populations [93, 94]. Broadhead et al confirmed the feasibility of using peer health advocates to engage HIV-infected drug users in care and described this social support structure as a more accessible alternative in the context of limited access to integrated substance-dependence treatment and HIV care. The intervention involved weekly provision of peer support and counseling and the provision of nominal monetary rewards to health advocates for successfully promoting their peers' engagement in care [95].

### **African-American and Latino Populations**

HIV-infected African American and Latino persons are significantly more likely than HIV-infected white persons to be diagnosed and initiated on treatment late in the course of HIV infection. In a modeling analysis using data from the national

HIV Research Network to describe HIV survival disparities among specific racial and ethnic groups, Losina et al found that late initiation and early discontinuation of ART were most pronounced among Hispanic subjects, with an additional 3.9 years of life lost from late initiation and early discontinuation of ART compared with 3.5 years of life lost for the entire study population [96]. In a retrospective cohort study, Ulett et al found 2.45 higher odds (95% CI, 1.60–3.74) of delayed linkage to HIV care among African American patients at an HIV/AIDS clinic [97]. Racial and ethnic minorities experience greater marginalization from the health care system and are more likely than their white counterparts to receive lower quality medical care [7, 9, 10, 98–104]. Distrust of the health care system can pose an additional barrier to engaging HIV-infected African American and Latino persons in treatment and care [105–107].

The complex interplay between social, cultural, and economic barriers to care among African American and Latino populations is not fully understood. However, socially and culturally sensitive linkage interventions have been developed in a manner consistent with the adaptation of culturally sensitive and client-centered HIV prevention interventions [108, 109]. Peer and outreach-based interventions that address structural barriers to care have demonstrated effectiveness in linking marginalized racial and ethnic minorities to treatment. The California Bridge Project used peer-based staff in outreach to locate out-of-treatment HIV-infected individuals [110]. Nearly a third of the 325 predominantly African American and Latino clients who reported no history of HIV treatment were linked to care. African American and Latino clients had 2.3 and 3.7 greater odds, respectively, of being linked to care than did white clients; the authors hypothesized that this difference was probably due to the use of outreach staff who reflected the client population demographically. An average of 15.4 contacts were reported among those who were successfully linked compared with 7.1 among those who were not, demonstrating the sustained effort required to engage marginalized individuals in care [110]. Rajabiun et al conducted qualitative interviews with predominantly underserved African American and Latino HIV-positive individuals at 7 sites of the Health Resources and Services Administration-funded Outreach Initiative to identify components of outreach programs that contributed to engagement and retention in HIV care by these populations [111]. Outreach staff improved access to care through locating physicians and clinics, linking clients to health insurance, accompanying them to medical appointments, and facilitating communication with providers. Staff support enhanced clients' self-efficacy and capacity to cope with the HIV diagnosis, and participants were provided with services such as transportation, food, and housing that addressed structural barriers to care. Forty-five percent of participants achieved undetectable viral loads by 12 months [112]. In another analysis of this multisite study, Cabral et al

found that participants reporting  $\geq 9$  contacts with outreach staff were half as likely as those with fewer contacts to have substantial gaps in primary care during a 12-month period [113]. Randomized, controlled trials are needed to assess the effect of outreach-based interventions on initiating and retaining disadvantaged minority populations in care [108]. The feasibility of integrating outreach interventions with substance-dependence treatment should also be explored [70, 108, 112].

Interventions that incorporate case management have also been successful in enhancing linkage to care among racial and ethnic minorities. The Antiretroviral Treatment Access Study (ARTAS) was a brief strengths-based case management intervention implemented in health departments and community-based organizations that involved client identification of strengths and abilities and the development of a personalized plan to acquire needed resources. ARTAS successfully linked 79% of recently diagnosed participants (497/626) to a primary HIV care provider within 6 months. Hispanic subjects were more likely to be engaged in HIV care than other racial and ethnic groups (odds ratio, 2.14; 95% CI, 1.03–4.43) [114]. Gardner et al conducted a randomized controlled trial of ARTAS in 4 states, comparing the efficacy of passive referral to a case management intervention in linking persons recently diagnosed to care. Individuals receiving the strengths-based case management intervention were 41% more likely to see a medical provider in consecutive 6-month intervals than those receiving passive referral to care (relative risk, 1.41; 95% CI, 1.1–1.6). The intervention had a stronger impact on Hispanic participants (relative risk, 2.16; 95% CI, 1.40–3.35) than on participants of other ethnicities [115].

Colocation of medical care and other support services has also been shown to be an important factor in engaging marginalized racial and ethnic minorities in care. Individuals who participated in the ARTAS intervention at a site colocated with HIV medical care providers were more likely to be linked to care [115]. In a program designed to facilitate HIV health care utilization among mostly minority populations in Bronx, New York, through colocation of case management, support groups, mental health, and harm reduction services, Cunningham et al found that case management and HIV support group visits were associated with 1.9 and 2.3 greater odds, respectively, of quarterly medical visits among participants [116].

## CONCLUSION

In summary, factors such as substance use, poverty, unemployment, lack of educational opportunities, and marginalization from the health care system constitute multilevel barriers to care for vulnerable subpopulations of HIV-infected heterosexual men. Consequently, interventions that address social and structural barriers to care through case management, colocation

of services, and outreach have been shown to enhance linkage to care across these subpopulations. Despite the broad efficacy of these interventions, those involved with the criminal justice system, substance users, and disadvantaged racial and ethnic minorities face distinct challenges to accessing care that also require more targeted strategies. Correctional facilities have the capacity to improve the health of HIV-infected individuals beyond incarceration, where they are arguably most vulnerable, by providing organized and coordinated discharge planning and linkage to intensive case management after release. Although substance-dependent populations are especially challenging to link to and retain in care, the emergence of integrated substance use and HIV treatment offers new possibilities to engage this population. The efficacy of peer- and outreach-based interventions in linking racial and ethnic minorities to care demonstrates the importance of socially and culturally sensitive interventions that foster trust in providers and provide means of overcoming structural barriers to care.

Future work is urgently needed to scale up successful models of linkage to care and to adapt these models to local contexts. This will require additional resources, but, most importantly, it will require collaboration across agencies and institutions and the innovative use of existing resources and capacities. Integration of services is an important example of improving efficiency in delivering comprehensive HIV care. The challenge and complexity of linking HIV-infected heterosexual men to care require renewed efforts to adapt interventions to the needs of diverse subpopulations.

## Acknowledgments

**Financial support.** The authors received no direct financial support for this manuscript, but support for related work is provided by the National Institutes of Health (NIH), Center for AIDS Research (grant number P30-AI-42853); the Center for Drug Abuse and AIDS Research (grant number P30DA013868); and the National Institute on Drug Abuse, NIH (grant number K23DA021095).

**Supplement sponsorship.** This article was published as part of a supplement entitled “Linkage, Engagement, and Retention in HIV Care,” supported by Bristol-Myers Squibb, Positive Charge Initiative. Editorial support for the supplement was provided by J. Turner at PAREXEL and was funded by Bristol-Myers Squibb, Positive Charge.

**Potential conflicts of interest.** A.N. has received consulting fees from Mylan. All other authors: no conflicts.

## References

- Centers for Disease Control and Prevention. HIV/AIDS surveillance report **1997**; 9:1–43. Available at: <http://www.cdc.gov/hiv/topics/reports/pdf/hivsur92.pdf>. Accessed 7 June 2010.
- Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2007**; 19:1–63. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf>. Accessed 7 June 2010.
- Castilla J, Sobrino P, De La Fuente L, Noguera I, Guerra L, Parras F. Late diagnosis of HIV infection in the era of highly active antiretroviral therapy: consequences for AIDS incidence. *AIDS* **2002**; 16:1945–51.

4. Samet JH, Freedberg KA, Savetsky JB, Sullivan LM, Stein MD. Understanding delay to medical care for HIV infection: the long-term non-presenter. *AIDS* **2001**; 15:77–85.
5. Wohl DA, Shain L, Adamian M, et al. HIV transmission risk behaviors among HIV-infected individuals released from prison [abstract 36]. In: Program and Abstracts of the 10th Conference on Retroviruses and Opportunistic Infections 10–14 February 2003. Boston.
6. Hu DJ, Byers R Jr., Fleming PL, Ward JW. Characteristics of persons with late AIDS diagnosis in the United States. *Am J Prev Med* **1995**; 11:114–9.
7. Oramasionwu CU, Brown CM, Lawson KA, Ryan L, Frei CR. Evaluating HIV/AIDS disparities for blacks in the United States: a review of antiretroviral and mortality studies. *J Natl Med Assoc* **2009**; 101:1221–9.
8. Oramasionwu CU, Brown CM, Ryan L, Lawson KA, Hunter JM, Frei CR. HIV/AIDS disparities: the mounting epidemic plaguing US blacks. *J Natl Med Assoc* **2009**; 101:1196–204.
9. Oramasionwu CU, Skinner J, Ryan L, Frei CR. Disparities in antiretroviral prescribing for blacks and whites in the United States. *J Natl Med Assoc* **2009**; 101:1140–4.
10. Moore RD, Stanton D, Gopalan R, Chaisson RE. Racial differences in the use of drug therapy for HIV disease in an urban community. *N Engl J Med* **1994**; 330:763–8.
11. Wohl AR, Tejero J, Frye DM. Factors associated with late HIV testing for Latinos diagnosed with AIDS in Los Angeles. *AIDS Care* **2009**; 21:1203–10.
12. Magnus M, Kuo I, Shelley K, et al. Risk factors driving the emergence of a generalized heterosexual HIV epidemic in Washington, District of Columbia networks at risk. *AIDS* **2009**; 23:1277–84.
13. Towe VL, Sifakis F, Gindi RM, et al. Prevalence of HIV infection and sexual risk behaviors among individuals having heterosexual sex in low income neighborhoods in Baltimore, MD: the BESURE study. *J Acquir Immune Defic Syndr* **2010**; 53:522–8.
14. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2000**; 12:1–44. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/pdf/hasr1202.pdf>. Accessed 7 June 2010.
15. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2001**; 13:1–44. Available at: [http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2001report/pdf/2001surveillance-report\\_year-end.pdf](http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2001report/pdf/2001surveillance-report_year-end.pdf). Accessed 7 June 2010.
16. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2002**; 14:1–50. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2002report/pdf/2002SurveillanceReport.pdf>. Accessed 7 June 2010.
17. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2003**; 15:1–46. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2003report/pdf/2003SurveillanceReport.pdf>. Accessed 7 June 2010.
18. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2004**; 16:1–46. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/pdf/2004SurveillanceReport.pdf>. Accessed 7 June 2010.
19. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2005**; 17:1–54. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/pdf/2005SurveillanceReport.pdf>. Accessed 7 June 2010.
20. Centers for Disease Control and Prevention. HIV/AIDS surveillance report **2006**; 18:1–55. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2006report/pdf/2006SurveillanceReport.pdf>. Accessed 7 June 2010.
21. Bartholomew LK, Parcel GS, Kok G, Gottlieb NH. Planning health promotion programs: an intervention mapping approach. San Francisco: Jossey-Bass, 2006.
22. Purcell DW, McCree DH. Recommendations from a research consultation to address intervention strategies for HIV/AIDS prevention focused on African Americans. *Am J Public Health* **2009**; 99:1937–40.
23. Metzger DS, Koblin B, Turner C, et al. Randomized controlled trial of audio computer-assisted self-interviewing: utility and acceptability in longitudinal studies. HIVNET Vaccine Preparedness Study Protocol Team. *Am J Epidemiol* **2000**; 152:99–106.
24. Perlis TE, Des Jarlais DC, Friedman SR, Arasteh K, Turner CF. Audio-computerized self-interviewing versus face-to-face interviewing for research data collection at drug abuse treatment programs. *Addiction* **2004**; 99:885–96.
25. Ghanem KG, Hutton HE, Zenilman JM, Zimba R, Erbeling EJ. Audio computer assisted self interview and face to face interview modes in assessing response bias among STD clinic patients. *Sex Transm Infect* **2005**; 81:421–5.
26. Macalino GE, Celentano DD, Latkin C, Strathdee SA, Vlahov D. Risk behaviors by audio computer-assisted self-interviews among HIV-seropositive and HIV-seronegative injection drug users. *AIDS Educ Prev* **2002**; 14:367–78.
27. Tempalski B, Lieb S, Cleland CM, Cooper H, Brady JE, Friedman SR. HIV prevalence rates among injection drug users in 96 large US metropolitan areas, 1992–2002. *J Urban Health* **2009**; 86:132–54.
28. Des Jarlais DC, Perlis T, Arasteh K, et al. HIV incidence among injection drug users in New York City, 1990 to 2002: use of serologic test algorithm to assess expansion of HIV prevention services. *Am J Public Health* **2005**; 95:1439–44.
29. Santibanez SS, Garfein RS, Swartzendruber A, Purcell DW, Paxton LA, Greenberg AE. Update and overview of practical epidemiologic aspects of HIV/AIDS among injection drug users in the United States. *J Urban Health* **2006**; 83:86–100.
30. Des Jarlais DC, Semaan S. HIV prevention for injecting drug users: the first 25 years and counting. *Psychosom Med* **2008**; 70:606–11.
31. Beckwith CG, Moreira CC, Aboshady HM, Zaller N, Rich JD, Flanagan TP. A success story: HIV prevention for injection drug users in Rhode Island. *Subst Abuse Treat Prev Policy* **2006**; 1:34.
32. Centers for Disease Control and Prevention. HIV infection among injection-drug users - 34 states, 2004–2007. *MMWR Morb Mortal Wkly Rep* **2009**; 58:1291–5.
33. Risser JM, Padgett P, Wolverson M, Risser WL. Relationship between heterosexual anal sex, injection drug use and HIV infection among black men and women. *Int J STD AIDS* **2009**; 20:310–4.
34. McCoy C, Lai S, Metsch L, Messiah S, Zhao W. Injection drug use and crack cocaine smoking: independent and dual risk behaviors for HIV infection. *Ann Epidemiol* **2004**; 14:535–42.
35. Williams ML, Elwood WN, Weatherby NL, et al. An assessment of the risks of syphilis and HIV infection among a sample of not-in-treatment drug users in Houston, Texas. *AIDS Care* **1996**; 8:671–82.
36. Booth RE, Kwiatkowski CF, Chitwood DD. Sex related HIV risk behaviors: differential risks among injection drug users, crack smokers, and injection drug users who smoke crack. *Drug Alcohol Depend* **2000**; 58:219–26.
37. Adimora AA, Schoenbach VJ, Martinson FE, Donaldson KH, Stancil TR, Fullilove RE. Concurrent partnerships among rural African Americans with recently reported heterosexually transmitted HIV infection. *J Acquir Immune Defic Syndr* **2003**; 34:423–9.
38. Rees V, Saitz R, Horton NJ, Samet J. Association of alcohol consumption with HIV sex- and drug-risk behaviors among drug users. *J Subst Abuse Treat* **2001**; 21:129–34.
39. Kalichman SC, Cain D, Zweben A, Swain G. Sensation seeking, alcohol use and sexual risk behaviors among men receiving services at a clinic for sexually transmitted infections. *J Stud Alcohol* **2003**; 64:564–9.
40. Shuper PA, Neuman M, Kanteres F, Baliunas D, Joharchi N, Rehm J. Causal considerations on alcohol and HIV/AIDS—a systematic review. *Alcohol Alcohol* **2010**; 45:159–66.
41. Baliunas D, Rehm J, Irving H, Shuper P. Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis. *Int J Public Health* **2010**; 55:159–66.

42. Rondinelli AJ, Ouellet LJ, Strathdee SA, et al. Young adult injection drug users in the United States continue to practice HIV risk behaviors. *Drug Alcohol Depend* **2009**; 104:167–74.
43. Cheng WS, Garfein RS, Semple SJ, Strathdee SA, Zians JK, Patterson TL. Binge use and sex and drug use behaviors among HIV(-), heterosexual methamphetamine users in San Diego. *Subst Use Misuse* **2010**; 45:116–33.
44. Lichtenstein B. Secret encounters: black men, bisexuality, and AIDS in Alabama. *Med Anthropol Q* **2000**; 14:374–93.
45. Williams CT, Mackesy-Amiti ME, McKirnan DJ, Ouellet LJ. Differences in sexual identity, risk practices, and sex partners between bisexual men and other men among a low-income drug-using sample. *J Urban Health* **2009**; 86:93–106.
46. Gorbach PM, Murphy R, Weiss RE, Hucks-Ortiz C, Shoptaw S. Bridging sexual boundaries: men who have sex with men and women in a street-based sample in Los Angeles. *J Urban Health* **2009**; 86:63–76.
47. Kent JB. Impact of foreign-born persons on HIV diagnosis rates among blacks in King County, Washington. *AIDS Educ Prev* **2005**; 17:60–7.
48. Centers for Disease Control and Prevention. Medical examination of aliens: removal of human immunodeficiency virus (HIV) infection from definition of communicable disease of public health significance. *Fed Regist* **2009**; 74:56547–62.
49. Beckwith CG, DeLong AK, Desjardins SF, et al. HIV infection in refugees: a case-control analysis of refugees in Rhode Island. *Int J Infect Dis* **2009**; 13:186–92.
50. Kerani RP, Kent JB, Sides T, et al. HIV among African-born persons in the United States: a hidden epidemic? *J Acquir Immune Defic Syndr* **2008**; 49:102–6.
51. Spaulding AC, Seals RM, Page MJ, Brzozowski AK, Rhodes W, Hammett TM. HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: declining share of epidemic but persistent public health opportunity. *LoS One* **2009**; 4:e7558.
52. Valera P, Epperson M, Daniels J, Ramaswamy M, Freudenberg N. Substance use and HIV-risk behaviors among young men involved in the criminal justice system. *Am J Drug Alcohol Abuse* **2009**; 35:43–7.
53. Grinstead OA, Faigles B, Comfort M, et al. HIV, STD, and hepatitis risk to primary female partners of men being released from prison. *Women Health* **2005**; 41:63–80.
54. Khan MR, Wohl DA, Weir SS, et al. Incarceration and risky sexual partnerships in a southern US city. *J Urban Health* **2008**; 85:100–13.
55. Kidder DP, Wolitski RJ, Pals SL, Campsmith ML. Housing status and HIV risk behaviors among homeless and housed persons with HIV. *J Acquir Immune Defic Syndr* **2008**; 49:451–5.
56. Morrow KM. HIV, STD, and hepatitis risk behaviors of young men before and after incarceration. *AIDS Care* **2009**; 21:235–43.
57. Khan MR, Doherty IA, Schoenbach VJ, Taylor EM, Epperson MW, Adimora AA. Incarceration and high-risk sex partnerships among men in the United States. *J Urban Health* **2009**; 86:584–601.
58. Margolis AD, MacGowan RJ, Grinstead O, Sosman J, Kashif I, Flanigan TP. Unprotected sex with multiple partners: implications for HIV prevention among young men with a history of incarceration. *Sex Transm Dis* **2006**; 33:175–80.
59. Rich JD, Holmes L, Salas C, et al. Successful linkage of medical care and community services for HIV-positive offenders being released from prison. *J Urban Health* **2001**; 78:279–89.
60. Harzke AJ, Ross MW, Scott DP. Predictors of post-release primary care utilization among HIV-positive prison inmates: a pilot study. *IDS Care* **2006**; 18:290–301.
61. Wang EA, White MC, Jamison R, Goldenson J, Estes M, Tulsy JP. Discharge planning and continuity of health care: findings from the San Francisco County Jail. *Am J Public Health* **2008**; 98:2182–4.
62. Clements-Nolle K, Marx R, Pendo M, Loughran E, Estes M, Katz M. Highly active antiretroviral therapy use and HIV transmission risk behaviors among individuals who are HIV infected and were recently released from jail. *Am J Public Health* **2008**; 98:661–6.
63. Springer SA, Pesanti E, Hodges J, Macura T, Doros G, Altice FL. Effectiveness of antiretroviral therapy among HIV-infected prisoners: reincarceration and the lack of sustained benefit after release to the community. *Clin Infect Dis* **2004**; 38:1754–60.
64. White MC, Tulsy JP, Estes M, Jamison R, Long HL. Health and health behaviors in HIV-infected jail inmates, 1999 and 2005. *AIDS Patient Care STDS* **2008**; 22:221–31.
65. Baillargeon J, Borucki MJ, Zepeda S, Jenson HB, Leach CT. Antiretroviral prescribing patterns in the Texas prison system. *Clin Infect Dis* **2000**; 31:1476–81.
66. Baillargeon JG, Giordano TP, Harzke AJ, Baillargeon G, Rich JD, Paar DP. Enrollment in outpatient care among newly released prison inmates with HIV infection. *Public Health Rep* **2010**; 125:64–71.
67. Grinstead O, Seal DW, Wolitski R, et al. HIV and STD testing in prisons: perspectives of in-prison service providers. *AIDS Educ Prev* **2003**; 15:547–60.
68. Bruce RD, Kresina TF, McCance-Katz EF. Medication-assisted treatment and HIV/AIDS: aspects in treating HIV-infected drug users. *AIDS* **2010**; 24:331–40.
69. Celentano DD, Galai N, Sethi AK, et al. Time to initiating highly active antiretroviral therapy among HIV-infected injection drug users. *AIDS* **2001**; 15:1707–15.
70. Rumpitz MH, Tobias C, Rajabian S, et al. Factors associated with engaging socially marginalized HIV-positive persons in primary care. *AIDS Patient Care STDS* **2007**; 21:S30–9.
71. Malta M, Strathdee SA, Magnanini MM, Bastos FI. Adherence to antiretroviral therapy for human immunodeficiency virus/acquired immune deficiency syndrome among drug users: a systematic review. *Addiction* **2008**; 103:1242–57.
72. Altice FL, Maru DS, Bruce RD, Springer SA, Friedland GH. Superiority of directly administered antiretroviral therapy over self-administered therapy among HIV-infected drug users: a prospective, randomized, controlled trial. *Clin Infect Dis* **2007**; 45:770–8.
73. Kerr T, Marshall A, Walsh J, et al. Determinants of HAART discontinuation among injection drug users. *AIDS Care* **2005**; 17:539–49.
74. Nunn A, Zaller N, Dickman S, Trimbur C, Nijhawan A, Rich JD. Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey. *Drug Alcohol Depend* **2009**; 105:83–8.
75. Mitchell SG, Kelly SM, Brown BS, et al. Incarceration and opioid withdrawal: the experiences of methadone patients and out-of-treatment heroin users. *J Psychoactive Drugs* **2009**; 41:145–52.
76. Kinlock TW, Gordon MS, Schwartz RP, Fitzgerald TT, O'Grady KE. A randomized clinical trial of methadone maintenance for prisoners: results at 12 months postrelease. *J Subst Abuse Treat* **2009**; 37:277–85.
77. Kinlock TW, Gordon MS, Schwartz RP, O'Grady K, Fitzgerald TT, Wilson M. A randomized clinical trial of methadone maintenance for prisoners: results at 1-month post-release. *Drug Alcohol Depend* **2007**; 91:220–7.
78. Kinlock TW, Gordon MS, Schwartz RP, O'Grady KE. A study of methadone maintenance for male prisoners: 3-month postrelease outcomes. *Crim Justice Behav* **2008**; 35:34–47.
79. Kinlock TW, Gordon MS, Schwartz RP, Fitzgerald TT. Developing and implementing a new prison-based buprenorphine treatment program. *J Offender Rehabil* **2010**; 49:91–109.
80. Green T, Zaller ND, Parikh A, et al. Initiation of buprenorphine during incarceration and linkage to treatment upon release [abstract WEPE0187]. In: Program of the XVIII International AIDS Conference 18–23 July 2010; Vienna.
81. Zaller ND, McKenzie M, Green T, et al. Initiation of methadone during incarceration and linkage to treatment upon release: results of a randomized control trial [abstract THPDX103]. In: Program of the XVII International AIDS Conference 18–23 July 2010; Vienna.
82. Magura S, Lee JD, Hershberger J, et al. Buprenorphine and methadone maintenance in jail and post-release: a randomized clinical trial. *Drug Alcohol Depend* **2009**; 99:222–30.

83. Springer SA, Chen S, Altice FL. Improved HIV and substance abuse treatment outcomes for released HIV-infected prisoners: the impact of buprenorphine treatment. *J Urban Health* **2010**; 87:592–602.
84. McKenzie M, Nunn A, Zaller ND, Bazazi AR, Rich JD. Overcoming obstacles to implementing methadone maintenance therapy for prisoners: implications for policy and practice. *J Opioid Manag* **2009**; 5:219–27.
85. Smith-Rohrberg D, Mezger J, Walton M, Bruce RD, Altice FL. Impact of enhanced services on virologic outcomes in a directly administered antiretroviral therapy trial for HIV-infected drug users. *J Acquir Immune Defic Syndr* **2006**; 43:S48–53.
86. Basu S, Smith-Rohrberg D, Bruce RD, Altice FL. Models for integrating buprenorphine therapy into the primary HIV care setting. *Clin Infect Dis* **2006**; 42:716–21.
87. Sullivan LE, Bruce RD, Haltiwanger D, et al. Initial strategies for integrating buprenorphine into HIV care settings in the United States. *Clin Infect Dis* **2006**; 43:S191–6.
88. Khalsa J, Vocci F, Altice F, Fiellin D, Miller V. Buprenorphine and HIV primary care: new opportunities for integrated treatment. *Clin Infect Dis* **2006**; 43:S169–72.
89. Lum PJ, Tulsy JP. The medical management of opioid dependence in HIV primary care settings. *Curr HIV/AIDS Rep* **2006**; 3:195–204.
90. Bruce R. Medical interventions for addictions in the primary care setting. *Top HIV Med* **2010**; 18:8–12.
91. Mizuno Y, Wilkinson JD, Santibanez S, et al. Correlates of health care utilization among HIV-seropositive injection drug users. *AIDS Care* **2006**; 18:417–25.
92. Lucas G, Chaudhry A, Hsu J, et al. Clinic-based treatment of opioid-dependent HIV-infected patients versus referral to an opioid treatment program. *Ann Intern Med* **2010**; 152:704–11.
93. Kushel MB, Colfax G, Ragland K, Heineman A, Palacio H, Bangsberg DR. Case management is associated with improved antiretroviral adherence and CD4+ cell counts in homeless and marginally housed individuals with HIV infection. *Clin Infect Dis* **2006**; 43:234–42.
94. Bristow DP, Herrick CA. Emergency department case management: the dyad team of nurse case manager and social worker improve discharge planning and patient and staff satisfaction while decreasing inappropriate admissions and costs: a literature review. *Lippincotts Case Manag* **2001**; 7:243–51.
95. Broadhead RS, Heckathorn DD, Altice FL, et al. Increasing drug users' adherence to HIV treatment: results of a peer-driven intervention feasibility study. *Soc Sci Med* **2002**; 55:235–46.
96. Losina E, Schackman BR, Sadownik SN, et al. Racial and sex disparities in life expectancy losses among HIV-infected persons in the United States: impact of risk behavior, late initiation, and early discontinuation of antiretroviral therapy. *Clin Infect Dis* **2009**; 49:1570–8.
97. Ulett KB, Willig JH, Lin HY, et al. The therapeutic implications of timely linkage and early retention in HIV care. *AIDS Patient Care STDS* **2009**; 23:41–9.
98. Wells K, Klap R, Koike A, Sherbourne C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *Am J Psychiatry* **2001**; 158:2027–32.
99. Porter J. The street/treatment barrier: treatment experiences of Puerto Rican injection drug users. *Subst Use Misuse* **1999**; 34:1951–75.
100. Office of Minority Health, U.S. Department of Health and Human Services. Assessment of state minority health infrastructure and capacity to address issues of health disparity. Washington, DC: US Department of Health and Human Services, 2000. Available at: <http://minorityhealth.hhs.gov/Assets/pdf/checked/1/OMHHealthDisparityFRSept00.pdf>. Accessed 7 June 2010.
101. Lundgren LM, Amodeo M, Ferguson F, Davis K. Racial and ethnic differences in drug treatment entry of injection drug users in Massachusetts. *J Subst Abuse Treat* **2001**; 21:145–53.
102. Gebo KA, Fleishman JA, Conviser R, et al. Racial and gender disparities in receipt of highly active antiretroviral therapy persist in a multistate sample of HIV patients in 2001. *J Acquir Immune Defic Syndr* **2005**; 38:96–103.
103. Smedley BD, Stith AY, Nelson AR. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press, 2003.
104. Zaller ND, Bazazi AR, Velazquez L, Rich JD. Attitudes toward methadone among out-of-treatment minority injection drug users: implications for health disparities. *Int J Environ Res Public Health* **2009**; 6:787–97.
105. Musa D, Schulz R, Harris R, Silverman M, Thomas SB. Trust in the health care system and the use of preventive health services by older black and white adults. *Am J Public Health* **2009**; 99:1293–9.
106. Dovidio JF, Penner LA, Albrecht TL, Norton WE, Gaertner SL, Shelton JN. Disparities and distrust: the implications of psychological processes for understanding racial disparities in health and health care. *Soc Sci Med* **2008**; 67:478–86.
107. Armstrong K, Ravenell KL, McMurphy S, Putt M. Racial/ethnic differences in physician distrust in the United States. *Am J Public Health* **2007**; 97:1283–9.
108. Bradford JB. The promise of outreach for engaging and retaining out-of-care persons in HIV medical care. *AIDS Patient Care STDS* **2007**; 21:S85–91.
109. McKleroy VS, Galbraith JS, Cummings B, et al. Adapting evidence-based behavioral interventions for new settings and target populations. *AIDS Educ Prev* **2006**; 18:59–73.
110. Molitor F, Waltermeyer J, Mendoza M, et al. Locating and linking to medical care HIV-positive persons without a history of care: findings from the California Bridge Project. *AIDS Care* **2006**; 18:456–9.
111. Rajabiun S, Mallinson RK, McCoy K, et al. “Getting me back on track”: the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care STDS* **2007**; 21:S209.
112. Naar-King S, Bradford J, Coleman S, Green-Jones M, Cabral H, Tobias C. Retention in care of persons newly diagnosed with HIV: outcomes of the Outreach Initiative. *AIDS Patient Care STDS* **2007**; 21:S40–8.
113. Cabral HJ, Tobias C, Rajabiun S, et al. Outreach program contacts: do they increase the likelihood of engagement and retention in HIV primary care for hard-to-reach patients? *AIDS Patient Care STDS* **2007**; 21:S59–67.
114. Gardner LI, Metsch LR, Anderson-Mahoney P, et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS* **2005**; 19:423–31.
115. Gardner LI, Marks G, Metsch LR, et al. Psychological and behavioral correlates of entering care for HIV infection: the Antiretroviral Treatment Access Study (ARTAS). *AIDS Patient Care STDS* **2007**; 21:418–25.
116. Cunningham CO, Sanchez JP, Li X, Heller D, Sohler NL. Medical and support service utilization in a medical program targeting marginalized HIV-infected individuals. *J Health Care Poor Underserved* **2008**; 19:981–90.