

<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 2012-2013 Standards of Care</b> General Standards Case Management (all CM service categories) Non-Medical Case Management (service linkage)	<b>8</b> 10 24 28
<b>2011 Mid-year Outcomes Report</b>	<b>31</b>
<b>Test and Treat: A New Paradigm for Slowing the Spread of HIV - HRSA CARE Action, January 2012</b>	<b>34</b>
<b>Transgender Post Release Case Management- Connecting to Care: Addressing Unmet Need in HIV (workbook 2), TARGET Center</b>	<b>42</b>
<b>Improving Linkages and Access to Care - What's Going on @ SPNS (HRSA) January 2012</b>	<b>47</b>

<p>HRSA Service Category Title: <b>RWGA Only</b></p>	<p><b>Non-medical Case Management</b></p>
<p>Local Service Category Title: <b>RWGA Only</b></p>	<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>
<p>Budget Type: <b>RWGA Only</b></p>	<p><b>Unit Cost</b></p>
<p>Budget Requirements or Restrictions: <b>RWGA Only</b></p>	<p><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></p>
<p>HRSA Service Category Definition: <b>RWGA Only</b></p>	<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>

<p>Local Service Category Definition:</p>	<p><b>A. <i>Service Linkage:</i></b> Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or <i>Not-In-Care</i> 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. <i>Youth targeted Service Linkage, Care and Prevention:</i></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>
<p>Target Population (age, gender, geographic, race, ethnicity, etc.):</p>	<p><b>A. <i>Service Linkage:</i></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 and</p>

	<p>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 Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 <u>newly-diagnosed or not-in-care</u> 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 Service Linkage Worker (SLW) 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 both <u>office- and field-based</u> and <b>may include the issuance of bus pass vouchers and gas cards per published guidelines</b>. Service Linkage targeted to Not-In-Care and/or</p>

	<p>Newly-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 both ECLIPS and CPCDMS data systems. 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: 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>
<p>Service Unit Definition(s): <b>RWGA Only</b></p>	<p>One unit of service is defined as 15 minutes of direct client services and allowable charges.</p>
<p>Financial Eligibility:</p>	<p>Refer to the RWPC’s approved <i>Financial Eligibility for Houston EMA Services</i>.</p>
<p>Client Eligibility:</p>	<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>

<p>Agency Requirements: <b>RWGA Only</b></p>	<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><u>Agency must comply with all applicable City of Houston DHHS ECLIPS and RWGA/HCPHES CPCDMS business rules and policies &amp; procedures.</u></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 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>
<p>Staff Requirements:</p>	<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 CPCDMS according to system 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</p>

	that meets or exceeds HCPHES/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements:	<p>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.</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 2013 How to Best Meet the Need Process**

<b>Step in Process: Council</b>		Date:
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:
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:
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: <b>04/19/12</b>
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**2012-2013 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.....	1
General Standards .....	2
Case Management (All Case Management Service Categories).....	16
Non-Medical Case Management (Service Linkage).....	20

## 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 2012-2013:

- 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
- 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 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.

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

## 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> <li>• Signed and dated by employee and supervisor (includes electronic signature)</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</p>	<p>Documentation of training in employee's record</p>

	<p>schedule for, but not limited to, case managers, and eligibility &amp; intake staff annually.</p> <p>All new employees must complete within ninety (90) days of hire.</p>	
<b>2.0</b>	<b>Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.</b>	
2.1	<p><u>Service Evaluation</u></p> <p>Agency has a process in place for the evaluation of client services.</p>	<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	<p><u>Subcontractor Monitoring</u></p> <p>Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include:</p> <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> <p>Reviewed Annually</p>	<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	<p><u>Staff Guidelines</u></p> <p>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.</p> <p>Reviewed Annually</p>	<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	<p><u>Work Conditions</u></p> <p>Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.</p>	<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	<p><u>Staff Supervision</u></p> <p>Staff services are supervised by a paid coordinator or manager.</p>	<ul style="list-style-type: none"> <li>• Review of personnel files indicates compliance</li> <li>• Review of Agency's Policies and Procedures Manual indicates</li> </ul>

		compliance
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	<u>Communication</u> There are procedures in place regarding regular communication with staff about the program and general agency issues.	<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	<u>Accountability</u> There is a system in place to document staff work time.	<ul style="list-style-type: none"> <li>• Staff time sheets or other documentation indicate compliance</li> </ul>
2.9	<u>Staff Availability</u> Staff are present to answer incoming calls during agency's normal operating hours.	<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	<u>Clients Rights and Responsibilities</u> 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: <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	<u>Confidentiality</u> Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit	<ul style="list-style-type: none"> <li>• Review of Agency's Policies and Procedures Manual indicates compliance</li> <li>• Clients interview indicates compliance</li> </ul>

	<p>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>• Agency's structural layout and information management indicates compliance</li> <li>• Signed confidentiality statement in each employee's personnel file</li> </ul>
<p>3.3</p>	<p><u>Consents</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Agency Policy and Procedure and signed and dated consent forms in client record</li> </ul>
<p>3.4</p>	<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</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>

	<p>entirely in the presence of the client. Any unused lines must have a line crossed through the space.</p>	
<p>3.5</p>	<p><u>Grievance Procedure</u>            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.            Grievance procedure includes but is not limited to:</p> <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, including a standardized grievance/complaint form available in a language and format understandable to the client</li> <li>• all complaints or grievances initiated by clients are documented on the Agency’s standardized form</li> <li>• resolution of each grievance/complaint is documented on the Standardized form and shared with client</li> <li>• confidentiality of grievance</li> <li>• addresses and phone numbers of licensing authorities and funding sources</li> </ul>	<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> <li>• Review of Agency’s Grievance file indicates compliance,</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2</li> </ul>
<p>3.6</p>	<p><u>Conditions Under Which Discharge/Closure May Occur</u>            A client may be discharged 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</li> </ul>	<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>

	<p>required when a client is terminated or suspended from services due to behavioral issues.</p> <ul style="list-style-type: none"> <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>	
<p>3.7</p>	<p><u>Client Closure</u>  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>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>	<ul style="list-style-type: none"> <li>Documentation in client record and in the Centralized Patient Care Data Management System</li> </ul>
<p>3.8</p>	<p><u>Client Feedback</u>  In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than 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 may 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>Agencies that serve an average of 100 or more</li> </ul>	<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> <li>Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1</li> </ul>

	<p>unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.</p>	
3.9	<p><u>Patient Safety (Core Services Only)</u>  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>  Provider shall maintain all client files.</p>	<ul style="list-style-type: none"> <li>• Review of agency’s policy and procedure for records administration indicates compliance</li> </ul>
<b>4.0</b>	<b><u>Accessibility</u></b>	
4.1	<p><u>Cultural Competence</u>  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</li> </ul>

		applications, consents, complaint forms, and notices of rights translated in client record
4.2	<u>Client Education</u> Agency demonstrates capacity for client education and provision of information on community resources	<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	<u>Special Service Needs</u> Agency demonstrates a commitment to assisting individuals with special needs	<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	<u>Provision of Services for low-Income Individuals</u> 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.	<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> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4</li> </ul>
4.5	<u>Proof of HIV Diagnosis</u> Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. 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 reasonable amount of certainty.	<ul style="list-style-type: none"> <li>• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3</li> </ul>
4.6	<u>Provision of Services Regardless of Current or Past Health Condition</u> 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.	<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	<u>Client Eligibility</u>	<ul style="list-style-type: none"> <li>• Documentation of HIV+ status, residence, identification and</li> </ul>

	<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>	<p>income in the client record</p> <ul style="list-style-type: none"> <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> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1</li> </ul>
<p>4.8</p>	<p><u>Re-evaluation of Client Eligibility</u>            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 payers 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 Payer 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 payer of last resort requirement</p> <ul style="list-style-type: none"> <li>• Agency must verify 3<sup>rd</sup> party payment coverage for eligible services at every visit or monthly (whichever is less frequent)</li> </ul>	<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> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2</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 ≤</p>	<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>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>	
<p>4.10</p>	<p><u>Information on Program and Eligibility/Sliding Fee Schedule</u></p> <p>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 program or agency.</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 eligibility and sliding fees on client record</li> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5</li> </ul>
<p>4.11</p>	<p><u>Linkage Into Core Services</u></p> <p>Agency staff will provide out-of-care clients with</p>	<ul style="list-style-type: none"> <li>• Documentation of client referral is present in client file</li> </ul>

	<p>individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.</p>	
<p>4.12</p>	<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 Agency’s plan must address:</p> <ul style="list-style-type: none"> <li>• Action steps to be taken Agency 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 service.</li> <li>• A revised plan for resumption of service, if necessary.</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>4.13</p>	<p><u>Intake</u>  The agency conducts an intake to collect required data</p>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>

	<p>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.</p> <p>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>• 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></p> <p>Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities.</p> <p>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></p> <p>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> <li>• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2</li> </ul>
<b>6.0</b>	<b>Point Of Entry Agreements</b>	
6.1	<p><u>Points of Entry (Core Services Only)</u></p> <p>Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with</p>	<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</li> </ul>

	<p>HIV Services policy approved by HRSA for the Houston EMA.</p>	<p>of Entry</p> <ul style="list-style-type: none"> <li>• Documentation of referrals and their follow-up</li> </ul>
<p><b>7.0</b></p>	<p><b>Emergency Management</b></p>	
<p>7.1</p>	<p><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.</p>	<ul style="list-style-type: none"> <li>• Emergency Preparedness Plan</li> <li>• Review of Agency’s Policies and Procedures Manual indicates compliance</li> </ul>
<p>7.2</p>	<p><u>Emergency Management Training</u>            In accordance with the Department of Human Services recommendations, all applicable agency staff must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security:</p> <ul style="list-style-type: none"> <li>• IS -100.HC – Introduction to the Incident command system for healthcare/hospitals</li> <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>	<ul style="list-style-type: none"> <li>• Documentation of all training including certificate of completion in personnel file</li> </ul>

	<p>The above courses may be accessed at: <a href="http://www.training.fema.gov">www.training.fema.gov</a>.</p> <p>Agencies providing support services only may complete alternate courses listed for the above areas</p> <p>All new employees are required to complete the courses within 90 days of hire.</p>	
7.3	<p><u>Emergency Preparedness Plan</u></p> <p>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></p> <p>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></p> <p>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	<p><u>Required Meetings</u>  <u>Case Managers and Service Linkage Workers</u>  Case managers and Service Linkage Workers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA.  Case Managers and Service Linkage Workers will attend the “Joint Prevention and Care Coordination Meeting” held annually and facilitated by the RWGA and the City of Houston STD/HIV Bureau.</p> <p>Medical Case Management (MCM), Clinical Case Management (CCM) and Service Linkage Worker Supervisors will attend on an annual basis a minimum of five (5) of the six (6) bi-monthly Supervisor meetings facilitated by RWGA (in the event a MCM or CCM supervises SLW staff the MCM or CCM must attend the Supervisor meetings and may, as an option, attend the networking</p>	<ul style="list-style-type: none"> <li>• Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)</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)

	meetings)	
1.2	<p><u>Required Training for New Employees</u></p> <p>Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101: A Foundation, through the State of Texas TRAIN website (<a href="https://tx.train.org">https://tx.train.org</a>) with a minimum of 70% accuracy. Incumbent case managers must successfully complete HIV Case Management 101: A Foundation, with a minimum of 70% no later than May 31, 2012. RWGA expects HIV Case Management 101: A Foundation, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA.</p> <p>For cultural competency training only, Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.</p>	<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>
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 RWGA.</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	<u>Initial Case Management Contact</u>	<ul style="list-style-type: none"> <li>• Documentation in client record</li> </ul>

	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.	
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 documented in the client record within 72 hours of their occurrence.</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 behalf of patient in progress notes</li> </ul>
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> </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>

	<ul style="list-style-type: none"> <li>Utilize a tracking mechanism to monitor completion of all case management referrals</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><b>1.0</b></p>	<p><b>Staff Requirements</b></p>	
<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><b>2.0</b></p>	<p><b>Timeliness of Services/Documentation</b></p>	
<p>2.1</p>	<p><u>Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed</u>                  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</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>

	<p>services as documented by the CPCDMS, or</p> <ul style="list-style-type: none"> <li>Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by 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 reassessment form as applicable must be utilized.</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>
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</p>	<ul style="list-style-type: none"> <li>Documentation in supervision notes, which must include:</li> </ul>

	<p>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>➤ 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> <ul style="list-style-type: none"> <li>• Supervision notes are never maintained in the client record</li> </ul>
<p>3.2</p>	<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>
<p>3.3</p>	<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>

**FY 2011 MID-YEAR OUTCOMES REPORTS HIGHLIGHTS**

**RYAN WHITE GRANT ADMINISTRATION**

**HARRIS COUNTY**

**PUBLIC HEALTH & ENVIRONMENTAL SERVICES**

**(HCPHES)**

Ryan White Part A  
 OUTCOME MEASURES RESULTS  
 FY 2011 Mid-Year Report

**Community-Based Case Management (Service Linkage)**  
 All Providers

Outcome Measure	Indicator	Data Collection Method
<b>1.0 Knowledge, Attitudes, and Practices</b>		
1.1. Increased or maintained utilization of primary care services	a. A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing community-based case management (service linkage) b. Percentage of HIV positive clients linked to outpatient/ambulatory medical care	<ul style="list-style-type: none"> <li>• CPCDMS</li> <li>• ECLIPS*</li> </ul>

**A. Primary Care:**

From 3/1/2011 through 8/31/2011, 4,013 clients utilized Part A community-based case management. According to CPCDMS, 1,361 (34%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing community-based case management, and 95 (2.4%) clients accessed primary care for the first time after utilizing community-based case management.

**B. HIV Positive Clients Linked to Care:**

This outcome measure has been deferred pending development of the ECLIPS system by the Houston Department of Health and Human Services.

*\*When implemented, now forecast to be April 2012*

Outcome Measure	Indicator	Data Collection Method
<b>1.0 Knowledge, Attitudes, and Practices</b>		
1.2 Increased or maintained utilization of support services	a. A minimum of 30% of clients will utilize Part A/B Local Pharmacy Assistance Program services after accessing community-based case management b. A minimum of 25% of clients will utilize Part A/B oral health care after accessing community-based case management c. Increase in the percent of clients who utilize mental health services after accessing community-based case management	<ul style="list-style-type: none"> <li>• CPCDMS</li> </ul>

From 3/1/2011 through 8/31/2011, 4,013 clients utilized Part A community-based case management.

#### **A. Local Pharmacy Assistance Program (LPAP):**

According to CPCDMS, 854 (21%) of these clients accessed LPAP services at least once during this time period after utilizing community-based case management, and 214 (5.3%) clients accessed LPAP services for the first time after utilizing community-based case management.

#### **B. Oral Health Care:**

According to CPCDMS, 551 (14%) of these clients accessed oral health care at least once during this time period after utilizing community-based case management, and 82 (2.0%) clients accessed oral health care for the first time after utilizing community-based case management.

#### **C. Mental Health Services:**

According to CPCDMS, 67 (1.7%) of these clients accessed mental health services at least once during this time period after utilizing community-based case management, and 19 (0.5%) clients accessed mental health services for the first time after utilizing community-based case management.



What Test and Treat Entails

Improving Health Outcomes

Linkage to Care

Optimizing Test and Treat

## TEST AND TREAT: A NEW PARADIGM FOR SLOWING THE SPREAD OF HIV

As the HIV/AIDS epidemic moves into its fourth decade, a new comprehensive strategy may offer hope for improving the care of people living with HIV/AIDS (PLWHA) and preventing transmission of the disease. This promising model is called “test and treat,” and its premise is as follows: HIV/AIDS can be eliminated from society if all adults are tested regularly and all infected persons are put on antiretroviral therapy (ART)—regardless of CD4 level. The jury is still out on whether this strategy is wise, but clinical trial findings demonstrating that patients with HIV who are receiving treatment are significantly less likely to pass on the infection suggest that the time has come to give serious attention to test and treat.<sup>1</sup> This issue of *HRSA CAREAction* is therefore devoted to examining the rationale, feasibility, challenges, and potential promise of this approach.

The U.S. Centers for Disease Control and Prevention’s (CDC’s) 2006 HIV testing recommendations seek to address wider scale HIV testing<sup>2</sup> (for example, they suggest HIV screening for people ages 13 to 64 in all health settings).<sup>3</sup> The Ryan White HIV/AIDS Treatment Extension Act of 2009 (which authorized the Ryan White HIV/AIDS Program) also directed Part A and B grantees to seek early identification of PLWHA unaware of their status and link them to care. Those recommendations, in combination with effective ART, the availability of newer and simpler antiretroviral (ARV) drug regimens, and the need to control the HIV epidemic, have generated much interest in the test-and-treat strategy among researchers, policy makers, and providers. The driving factor, of course, is the clinical trial findings that PLWHA on ART are far less likely to transmit HIV to others.

### DID YOU KNOW?

- ▶ When patients are on ART they are less infectious.
- ▶ The test-and-treat strategy has similar goals to the National HIV/AIDS Strategy.



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 **DIRECTOR'S LETTER**

Early diagnosis of HIV, linkage to care, and reduction of viral load—and, thus, decreased infectiousness—have always been priorities of HRSA's. In 2009, the Ryan White HIV/AIDS Treatment Extension Act specifically directed Part A and B grantees to seek earlier identification of people living with HIV/AIDS unaware of their status and link them to care.

We know when patients are aware of their status they're less likely to transmit the virus. Recent clinical research has also shown overwhelmingly that when people living with HIV/AIDS are adherent to antiretroviral therapy, they are far less likely to pass on the infection than those off-treatment.

This new research warrants evaluation of test and treat, a broad-based strategy for reaching, engaging, and treating people living with HIV/AIDS. In this issue of *HRSA CARE Action* we examine what test and treat entails, the feasibility of this model, the challenges associated with expanding treatment regardless of CD4 level, and what changes health reform and a National HIV/AIDS Strategy may mean for such an approach.

Examining potentially promising new strategies like test and treat is just one more example of how HRSA is always looking for ways to *do better* and *do more* for people living with HIV/AIDS.

Deborah Parham Hopson  
HRSA Associate Administrator for HIV/AIDS

### **HRSA CARE Action**

#### **Publisher**

U.S. Department of Health and Human Services  
Health Resources and Services Administration, HIV/AIDS Bureau  
5600 Fishers Lane, Room 7-05  
Rockville, MD 20857  
Telephone: 301.443.1993

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#### **Photographs**

Cover: Finger-prick HIV testing in an outreach van in Brooklyn, N.Y.

Additional copies are available from the HRSA Information Center, 888.ASK.HRSA, and may be downloaded at [www.hab.hrsa.gov](http://www.hab.hrsa.gov). This publication lists non-Federal resources to provide additional information to consumers. The views and content in those resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its components.

### **WHAT DOES TEST AND TREAT ENTAIL?**

The test and treat approach is based on two theories:

1. Early diagnosis and treatment will decrease the risk of HIV/AIDS and non-HIV/AIDS-related health problems in PLWHA.
2. Reduction of viral load to undetectable levels will dramatically reduce the current transmission rate of HIV.<sup>4</sup>

Test and treat therefore has two goals:

1. Improve the health outcomes in people who do not yet know their serostatus.
2. Reduce HIV transmission, because PLWHA who are receiving treatment are far less likely to transmit infection to others.

To achieve those goals, the test-and-treat framework includes multiple systems of care that would include the following components:

- ▶ Testing and identification of PLWHA as soon as possible. (To read about testing requirements and consent, see [www.kff.org/hivaids/upload/6094-05.pdf](http://www.kff.org/hivaids/upload/6094-05.pdf).)
- ▶ Linkage of people testing positive for HIV to HIV care—that is, ensure transition from test site to care setting using evidence-based linkage models, such as the Antiretroviral Treatment Access Study (ARTAS; see [www.cdc.gov/hiv/topics/prev\\_prog/ahp/resources/factsheets/ARTASSII.htm](http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/factsheets/ARTASSII.htm)) and offer ART, if the patient is eligible.
- ▶ Patient education to encourage self management and facilitate retention in care, adherence to treatment, and prevention of sexually transmitted infections (STIs).
- ▶ Supportive services for promotion of sexual health maintenance.
- ▶ Monitoring and evaluation of a test-and-treat strategy using HIV/AIDS Bureau (HAB) performance measures. (See <http://hab.hrsa.gov/deliverhivaids/habperformmeasures.html> to learn more.)

### **Rationale for Test and Treat**

Test and treat is a comprehensive strategy that could make a significant difference in the HIV epidemic.<sup>5</sup> As such, this article examines test and treat's two primary goals.

### **Improving Health Outcomes in People Who Do Not Know Their Serostatus**

Several indicators support increasing the number of people aware of their HIV status. In the United States there are more than 1 million estimated PLWHA.<sup>6</sup> According to the latest CDC estimates, approximately 50,000 new HIV infections occur each year,<sup>7,8</sup> and of

**Getting people tested and into treatment as early as possible is a practical goal. [However], we have a challenge in identifying people earlier and getting them into care.**

—Melanie Thompson, AIDS Research Consortium of Atlanta

the more than 1 million PLWHA, an estimated 21 percent are unaware of their serostatus.<sup>9</sup> The highest prevalence is in urban areas, where many people at high risk of HIV infection live. In some major cities, HIV seroprevalence exceeds 1 to 2 percent, and in the New York City population of men who have sex with men (MSM), it exceeds 13 percent.<sup>10</sup> These data underscore the need to increase testing.

According to one meta-analysis, people unaware of their serostatus are more likely to engage in risky health behaviors, such as unprotected vaginal and anal intercourse, than are people who know their serostatus.<sup>11</sup> In addition, 35 to 45 percent of people with newly diagnosed HIV infection develop AIDS within 1 year after diagnosis, representing late entry into care (i.e., they enter care later in the course of the disease).<sup>12</sup> Many people present at emergency rooms with extremely compromised immune systems and AIDS-related complications and learn their HIV status only when tests are initiated. According to the North American AIDS Cohort Collaboration on Research and Design, the median CD4 count at time of presentation increased from 256 cells/mm<sup>3</sup> in 1997 to 317 cells/mm<sup>3</sup> in 2007. Given that the U.S. Department of Health and Human Services (HHS) guidelines recommend initiating ART at 350–500 cells/mm<sup>3</sup>,<sup>13</sup> it is noteworthy that for this ten-year span, the median CD4 count at diagnosis indicated that ART should be initiated.

If fully implemented, test-and-treat programs could help increase the number of people receiving early diagnoses when their immune systems are relatively healthy and, furthermore, could produce a decrease in the number of people unaware of their status who, without HIV treatment, are more likely to infect others. It is clear that test-and-treat has the potential to save lives.

### Reducing HIV Transmission

A growing body of evidence suggests that earlier treatment can extend lives and reduce mortality.<sup>14</sup> A test-and-treat framework would start PLWHA on ART earlier in disease course than the current HHS recommendations and could have a major influence on the HIV epidemic. As more people with higher CD4 counts began and maintained treatment, infectiousness would decrease. Linkage to and retention in high-quality HIV primary care is essential for the strategy to work, however.<sup>15</sup>

Some ecological studies show that HIV incidence may be decreasing in locales with high ARV coverage. One study showed that by lowering average community viral load\* in the city of San Francisco, HIV infections could be decreased. In addition, viral load monitoring could help public health professionals better allocate resources and evaluate prevention and treatment programs in a particular community. Such a tool is most likely to be effective in communities such as San Francisco, Boston, and Vancouver, where prevention, care, and treatment are well supported and implemented.

One of the major reasons to support the test-and-treat

approach is simply the effectiveness of ART in reducing HIV transmission. According to one source, even with the phenomena of drug-resistant virus and adherence difficulties only 15 to 25 percent of PLWHA on treatment have detectable virus.<sup>17</sup> Moreover, evidence indicates that PLWHA with undetectable virus may not transmit the virus readily to others. In fact, the data are compelling that effective ART reduces sexual transmission. In one meta-analysis examining 11 cohorts of serodiscordant heterosexual partners in which the partner with AIDS was treated with ART and had <400 copies/mL, no HIV transmission occurred.<sup>18</sup> One of the most exciting breakthroughs at the recent International AIDS Society Conference in Rome was a report of the HIV Prevention Trials Network (HPTN) 052 study showing that HIV-infected men and women who were on ART had a 96-percent reduced risk of transmitting the virus to their uninfected sexual partners.

Several studies have modeled test and treat, and the very concept of treating our way out of the epidemic has been around since the 1990s, according to Ward Cates, president for research at Family Health International.<sup>19,20</sup> The most cited modeling study, by Granich et al., used South Africa as a test case and showed that a universal test-and-treat model could reduce incidence significantly.<sup>21</sup> Most models are just that, however—concepts or estimates that come with many caveats and assumptions. The true test will be real-world scenarios implemented in communities of need.

To better assess the feasibility and effectiveness of a test-and-treat approach, the HIV Prevention Trials Network (HPTN) recently launched a 3-year controlled study, HPTN 065 (Box 1). The study includes an analysis of test-and-treat's effectiveness as a "prevention-with-positives" strategy. HPTN 065 marks an important step forward in determining the potential of a large-scale rollout of a test-and-treat strategy.<sup>22</sup>

### CHALLENGES TO IMPLEMENTATION OF TEST AND TREAT

Many challenges, ranging from HIV stigma to inadequate funding for testing, care, and treatment, must be addressed—and overcome—for the test-and-treat strategy to be fully effective at the individual level. New research would have to be completed in order to answer remaining questions regarding the framework's impact on local and regional public health.

Test and treat implementation has three main challenges:

1. Testing people at greatest risk
2. Providing adequate resources
3. Maintaining people in care in the face of systemic challenges.

If any component in the test-and-treat strategy framework, as outlined earlier (on page 2), is incomplete or underutilized (e.g., testing sites, inadequate coverage of ART), the entire strategy is likely to be less effective.

\*Community viral load is the mean viral load in PLWHA in a given community; it is a population marker of transmission risk.

## ➔ BOX 1. THE HPTN 065 STUDY

The main purpose of the 36-month HPTN 065 study, which began in 2010, is to assess a community-level test-and-treat strategy in the United States. The study, which is known as TLC-Plus (testing and linkage to care plus treatment) will evaluate the probability of program outcomes and assess the effectiveness of others.

The primary outcomes of the TLC-Plus package of interventions will be determined by measuring changes in key parameters in two intervention communities (Bronx, NY, and Washington, DC). Observations in four nonintervention control communities (Chicago, Houston, Miami, and Philadelphia) will help assess the influence of current trends in HIV testing and care expansion in the United States.

TLC-Plus uses innovative approaches, including a community focus, multicomponent strategies that include behavioral and medical interventions, analysis of routinely reported HIV

surveillance data to determine key outcomes, and partnership with local departments of health and the CDC.

This study is a proof-of-concept formative study. It will provide key information that could guide the design and anticipate the costs of a future large, randomized, community-level clinical trial evaluating full implementation of a test-and-treat strategy in the United States. Findings could also inform test-and-treat efforts in other developed countries.

More information is available at [www.hptn.org/research\\_studies/hptn065.asp](http://www.hptn.org/research_studies/hptn065.asp).

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Source: Adapted from HIV Prevention Trials Network. *HPTN 065. 2010*. Available at: [www.hptn.org/research\\_studies/hptn065.asp](http://www.hptn.org/research_studies/hptn065.asp). Accessed May 31, 2011.

### **Testing People at Greatest Risk**

HIV testing has expanded greatly since the epidemic began. In the early days, as a result of stigma, no consensus on the desirability of HIV testing existed. The notion of routine testing was fraught with privacy concerns, and a positive test was likened to a death sentence. Expansion of testing came about over the subsequent years as both a prevention strategy (to educate about HIV and risk behaviors) and in response to the availability of treatment with AZT. The attitudes toward testing changed dramatically in 1996 with the advent of combination therapy. Getting ART meant survival. Now, routine testing is seen in a more positive light, as a way to increase identification of people with HIV and get them into care and a way to educate people about HIV prevention.<sup>23</sup>

People most at risk for HIV—minority or young MSM and people without access to health care, for example—are often the hardest to reach. Consequently, HRSA has launched many projects and initiatives to reach these groups. (See “National HIV/AIDS Strategy” section below.)

### **Providing Adequate Resources**

According to Murray Penner, deputy executive director of the National Alliance of State and Territorial AIDS Directors (NASTAD), the current economic climate makes the resources needed for routine testing particularly challenging, because Medicaid in most States is not required to reimburse for it.

Pressure on State AIDS Drug Assistance Program (ADAP) resources has continued to increase over the years as a result of increased costs of care management, decreased mortality, more new drugs, and relatively stable infection rates. State ADAPs are struggling with the high cost of ARV medications, and the environment is not likely to improve any time soon, given the poor economy and its crippling effects on State budgets. At the same time, the number of people needing treatment has increased. According to NASTAD, as of August 11, 2011, a total of 9,217 eligible people were on ADAP waiting lists in 12 States, and an additional 19 States had contained

costs through measures including monthly caps on enrollment, formulary reductions, and restricting financial eligibility. Ten other States are considering tightening eligibility requirements in 2012.<sup>24</sup>

The Ryan White HIV/AIDS Program is the payor of last resort for people with HIV. To help address treatment access challenges, the Ryan White HIV/AIDS Program now allocates more money to ADAP than to any other program component: \$885 million in FY 2011. State ADAPs also receive funds from their respective State governments. In addition, HRSA provided an extra \$25 million to States with ADAP waiting lists in 2010 to assist in reducing the size of their waiting lists. Still, need continues to outweigh available funding.

ADAPs, however, are not the only way for low-income PLWHA to access medications. Pharmaceutical assistance programs (PAPs) help some patients access medications (see <http://fairpricingcoalition.org>). Welvista, a new nonprofit partnership between a mail order pharmacy and Heinz Family Philanthropies, is working to fill the ADAP waiting list gap.<sup>25</sup> To ensure increased access to ART for PLWHA, however, PAPs also have to implement cost-containment measures, such as rebates from pharmaceutical manufacturers, improved drug purchasing and distribution systems, and pharmacy-based discounts on drugs (e.g., use of generics when available) (To learn more about HRSA’s efforts in addressing ADAP challenges, see [www.youtube.com/watch?v=Zp7QNFw\\_1y8](http://www.youtube.com/watch?v=Zp7QNFw_1y8).)

AIDS service organizations are having to become ever more creative in meeting client needs and increasingly collaborative with local partners to reduce duplication of services and decrease costs. Even though President Obama requested an increase in the FY 2012 Federal budget for HIV/AIDS programs, programs continue to operate under serious financial constraints.

Data show that HIV testing is cost effective when compared to the expense of treatment for HIV/AIDS. A 2006 study found that the average lifetime cost of care for a PLWHA is \$618,900 over 24 years.<sup>26</sup> Additionally, some clinics and public hospitals

*If we expand to [people] who are undiagnosed and need treatment, and then they stay on treatment, it will continue to push the AIDS Drug Assistance Program limit.*

—Murray Penner, Deputy Executive Director, National Alliance of State and Territorial AIDS Directors

are eligible for 340b drug pricing which may assist in curtailing costs. The 340b program sets an upper limit on the price that drug manufacturers receive from covered entities for outpatient drugs. For information on whether your facility qualifies, you can inquire with your pharmacy director. Hospitals and providers may also participate in group-purchasing arrangements to reduce the cost of test kits. For information, contact your laboratory or purchasing directors. (For further details, go to [www.hrsa.gov/opa/](http://www.hrsa.gov/opa/).)

What remains to be seen regarding access to HIV/AIDS treatment for low-income persons is the impact of implementation of the Patient Protection and Affordable Care Act and, specifically, expansion of Medicaid in 2014.

### **Maintaining People in Care: Systemic Challenges**

While AIDS service organizations and other Ryan White HIV/AIDS Program grantees work together to remove patient-level obstacles to engagement and retention in care, systemic problems that prevent patients from accessing appropriate care must be overcome to make the test-and-treat model viable. For example, HIV testing and counseling may be a new endeavor at some community health clinics.

Various models exist to address systemic challenges and improve patient health outcomes. For example, the Louisiana State University (LSU) Health Care Services Division, which runs several public hospitals, and the Louisiana Office of Public Health (OPH) created a partnership called the Louisiana Public Health Information Exchange, or LaPHIE. The partnership was made possible through funding from HRSA's Special Projects of National Significance and sought to remove system-level barriers, improve organizational communication strategies, and enhance patient health outcomes. In short, LaPHIE established an electronic link between OPH clinics and LSU's electronic medical records system to link into care PLWHA who are not in care. OPH maintains the list of PLWHA in the State and also receives and tracks their CD4 and viral load test reports.

LaPHIE automatically generates a message that a certain patient is "out of care" if there is no CD4 or viral load test result reported for a year. If that patient then enters care at any of the LSU hospitals, a message shows up in the electronic records system. In addition, the doctor or nurse gets an instant message that the person tested HIV positive but is not currently receiving care, providing an opportunity to reengage that patient. In the program's first 14 months, 199 patients were identified as out of care, and of those, 89 have returned to care.<sup>27</sup> LaPHIE highlights what's possible when grantees join forces and look for innovative ways to overcome systematic challenges and, subsequently, improve clinical outcomes.

In the United States in 2003, approximately 67 percent of PLWHA receiving care were eligible for treatment on the basis of the 350 CD4 cells/mm<sup>3</sup> threshold, yet 21 percent of those PLWHA were not being treated.<sup>28</sup> Among patients on ART, however, 80 percent were viral-load suppressed, meaning

that when they received continuous treatment, their infection decreased. These data underscore the importance of getting PLWHA into treatment and ensuring adherence (see Box 2). Although socioeconomic and other barriers have always thwarted the goal of getting PLWHA into care, and will continue to pose a problem even with increased testing and treatment, programs like LaPHIE illustrate that providers can successfully address some of the barriers.

The Patient Protection and Affordable Care Act, when implemented as written, will help remove several systemic barriers that stand in the way of people receiving HIV care. For example, the act will prohibit pre-existing condition requirements, so PLWHA cannot be dropped or denied insurance coverage. Coverage is required for young adults up to age 24 who are on their parents' insurance plan and lifetime caps on coverage will be removed. These changes and others are intended to improve access for people who might otherwise be without care or supported entirely by Ryan White. The Patient Protection and Affordable Care Act, coupled with the National HIV/AIDS Strategy, is a formidable intervention that should remove many systemic barriers. Implementation of the act is likely to improve the success of test and treat. (To read additional changes that the Patient Protection and Affordable Care Act would bring see, [www.kff.org/healthreform/upload/8061.pdf](http://www.kff.org/healthreform/upload/8061.pdf).)

### **Linkage to Care**

Widespread and timely access to treatment is required for a successful test-and-treat program. Because of poor or inadequate linkages to care or lack of patient follow-up on referrals, it is common for people diagnosed with HIV to delay treatment. Delays, however, affect individual health outcomes, and untreated PLWHA with detectable viral levels are at greater risk of infecting others.<sup>29,30</sup>

A host of linkage-to-care models exist; their efficacy varies depending on the population and service context. Examples include ARTAS, described earlier. Coordination and collaboration among providers is critical.<sup>31</sup> Many peer/patient navigator programs have had success in this area. Patient navigators are often nonmedical health care workers who assist patients in learning about their disease and steering them toward treatment and other services. Peer navigators and other linkage models help remove systemic barriers so that patients can better access the services they need. (To learn more about navigator programs in other disease contexts, visit <http://bhpr.hrsa.gov/grants/patientnavigator/outreachandprevention.html>.)

Linking people to care is only half the battle. Once patients are engaged, they must subsequently be retained in care. HRSA has examined this topic in detail and has recently launched a national campaign to examine the issue and identify best practices. (To access technical assistance materials, visit [www.careacttarget.org/topics.asp#engaging](http://www.careacttarget.org/topics.asp#engaging); to learn about the campaign, see [www.incarecampaign.org](http://www.incarecampaign.org).)

## ➔ BOX 2. ADHERENCE TO TREATMENT

Adherence is a problem with any lifelong therapy, although fixed-dose drug regimens and other innovations may have made it easier for PLWHA to achieve viral suppression. Regardless of the regimen, adherence must be supported and should be a part of patient education and counseling. Poor adherence has serious public health consequences, because missing doses may create drug-resistant virus that could be transmitted. The benefits of adherence are clear: Two recent studies found that 78 to 87 percent of people receiving ART had an undetectable viral load.

Some drugs may be toxic to patients with certain comorbidities, or competing life priorities may interfere with treatment. Some patients have intolerable side effects with treatment or may be reluctant to initiate treatment because they fear toxicities or unknown long-term side effects. Providers must address these and other challenges when working with

patients to achieve proper adherence to a treatment regimen.

For more information on adherence, see the AIDS Education and Training Center site: [www.aidsetc.com/aidsetc?page=home-search&post=1&SearchEntry=adherence](http://www.aidsetc.com/aidsetc?page=home-search&post=1&SearchEntry=adherence), and the TARGET Center site and search the TA library for “adherence”: [www.careacttarget.org](http://www.careacttarget.org).

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### Retention in Care

Several population-based studies in the United States have shown that a proportion of PLWHA fail to receive care in any year. According to one study, as many as 30 percent of newly diagnosed PLWHA did not attend their initial HIV primary care appointment in the period studied.<sup>32</sup> Certainly, the number of PLWHA who receive care increases as the years progress. One estimate is that 75 percent of PLWHA receive care at the time of diagnosis and that 3 to 5 years later, 80 to 90 percent are in care.<sup>33</sup> Several cohort studies, however, show that in some settings, 22 to 44 percent of patients are entirely lost to follow-up. Lack of appropriate care translates to fewer people receiving ART, preventative care, and other medical services.<sup>34,35</sup> Once the National HIV/AIDS Strategy and Patient Protection and Affordable Care Act are implemented, however, the Centers for Medicaid and Medicare Services, HRSA, and CDC will have collaborated to leverage resources and make programs more efficient.<sup>36</sup>

### OPTIMIZING TEST AND TREAT

Every component of test and treat must be optimized if the strategy is to be truly effective, as noted earlier. The existing health care infrastructure presents resource challenges, even where model programs for people with HIV have been created. For example, the HRSA Shortage Designation Branch develops shortage designation criteria and uses them to decide whether a geographic area, population group, or facility is a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) or Population (MUP). Implementing a test-and-treat strategy would be particularly difficult in these areas as resources are already limited. As such, additional support would likely be warranted in HPSAs, MUAs, and MUPs to get a test-and-treat strategy to function optimally. (For more information, see <http://bhpr.hrsa.gov/shortage/>.)

Provider and patient education is critical in every component of test and treat. As clinicians who began providing HIV/

AIDS care at the start of the epidemic retire, new providers will need training. Programs such as the AIDS Education and Training Centers (<http://aidsetc.org/>) will continue to be the leaders in education. As health care reform is implemented and more people gain access to care, the number of patients entering HIV primary care will increase, as will the need for patient—and provider—education. These changes represent an exciting time in public health, but one of many new challenges. (To stay abreast of HRSA's latest publications on health care strategies see, [www.hab.hrsa.gov/newspublications/index.html](http://www.hab.hrsa.gov/newspublications/index.html), [www.careacttarget.org/index.asp](http://www.careacttarget.org/index.asp), and [www.hab.hrsa.gov/abouthab/partfspns.html](http://www.hab.hrsa.gov/abouthab/partfspns.html).)

### NATIONAL HIV/AIDS STRATEGY

One of President Obama's top HIV/AIDS policy priorities has been the development of the National HIV/AIDS Strategy.<sup>37</sup> The three priorities of the strategy are (1) to reduce HIV incidence, (2) increase access to care and optimize health outcomes, and (3) reduce HIV-related health disparities. Because test-and-treat goals dovetail with the National HIV/AIDS Strategy, the approach will receive support at the Federal level if it is demonstrated to be effective in joining research, outreach, and care services and treatment delivery. As Andrea Weddle, executive director of the HIV Medical Association, explains:

There are a lot of opportunities to see [Test and Treat] work on a larger scale despite the ambitious goals. On a national scale we need to realistically think about it as a targeted roll out; even the Affordable Care Act will roll out on a State-by-State basis. This is where the National HIV/AIDS Strategy [will] play a role using integration of existing programs and skills.

The National HIV/AIDS Strategy and health care reform are great steps forward in curtailing HIV disease in our country. The Ryan White HIV/AIDS Program will continue to remain intact and integral to achieving this goal. Other Federal initiatives to

**TLC-Plus [Testing and Linkage to Care plus Treatment] is the foundation of the National HIV/AIDS Strategy, and we know best practices cannot be realized without good linkages to care and should be supported by all in the public and private sector, when and where necessary.**

—Tiffany West-Ojo, District of Columbia Department of Health

help individuals and communities most disproportionately affected by HIV disease include the following:

- ▶ The Ryan White Program's HIV/AIDS Quality Management Cross-Part Collaborative.
- ▶ The SPNS System Linkages and Access to Care initiative, and
- ▶ The HHS cross-agency 12-cities project. (The project supports and accelerates comprehensive HIV/AIDS planning and cross-agency response in the 12 U.S. jurisdictions that bear the highest AIDS burden in the country.)

Again, prevention efforts are necessary to decrease infection rates and, by extension, demand for ART. As such, these initiatives help further blend prevention and treatment services. In addition, they encourage strengthened cooperation among local, State, and Federal entities to increase effectiveness in decreasing HIV transmission.

HAB's performance measures will also allow HIV providers to better monitor their quality of care delivery and help

identify areas for improvement. These uniform measures allow grantees to more readily share information and streamline their collaboration and evaluation.

Together, the HHS projects listed above work to increase health insurance coverage for patients who are un- or underinsured, foster stronger interagency collaboration, and encourage better coordination of HIV services across Ryan White HIV/AIDS Program Parts. The National HIV/AIDS Strategy, as reflected in the test-and-treat strategy, and the other Federal projects suggest that HIV/AIDS care is shifting toward a new paradigm in which fewer people will go undiagnosed. This shift would represent a more comprehensive strategy that would offer treatment as early as possible and increased support for caseworkers, clinicians, and caregivers. Recent legislation surrounding HIV and health care are important first steps as we move into this next decade of addressing HIV/AIDS in the United States.

## ➔ PROS AND CONS OF TEST AND TREAT <sup>38,39,40</sup>

PRO	CON
Widespread effective antiretroviral treatment may lower the community viral load.	Widespread testing and treatment has large financial cost implications; as more people are engaged into test and treat, more resources will be needed.
More people would benefit from treatment.	Many barriers to HIV testing remain.
Evidence shows test and treat works.	Modeling studies are flawed.
Test and treat would identify more HIV-positive people.	We may not be able to treat our way out of the epidemic.
The strategy would help mitigate health disparities.	Demand for treatment exceeds supply.
When risk reduction counseling is included in HIV testing, it allows providers to discuss risk behaviors and harm reduction to both HIV-positive persons as well as HIV-negative persons.	Behavioral disinhibition/risk compensation would compromise any decrease in incidence.
Test and treat would enable monitoring and retention for people who start treatment.	The current testing system makes capturing acute infections difficult.
Test and treat would help link and retain people in care.	Viral suppression may not be possible for everyone.
Test and treat would present opportunities for prevention with patients' partners.	Current safety net resources should be used efficiently.
People would receive referrals to supportive services earlier in disease course.	Widespread treatment is unsustainable
People could begin treatment earlier in disease course.	Treatment initiation may take time. Unknown long term treatment toxicities.
Sexually transmitted infection screening, treatment, and sexual health education would be facilitated	Stigma and discrimination continue to exist.

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# TRANSGENDER POST-RELEASE CASE MANAGEMENT



**TRANSGENDER POST-RELEASE CASE MANAGEMENT** is an individual level intervention which links transgender HIV+ individuals soon to be released or recently released from a correctional facility to health services. The key characteristics of Transgender Post-Release Case Management are: face-to-face meetings with inmates in a local facility or collect call conversations from distant facilities; use of case managers who are from the primary target population; acceptance and non-judgment of the client; development of a risk reduction plan that includes HIV and health service goals; and tracking of the client’s progress.

### CURRENT ACTIVITY SETTING

*Community-Based Organization for Ex-Offenders,  
Case Management Discharge Planning*

- ✓ Directly links the client to medical care
- ✓ Gets the client in a conversation about starting medical care
- ✓ Brings the agency closer to where HIV+ people are so that the conversation can begin

## I. DESCRIPTION

### OBJECTIVES

- ▶▶ To help transgender individuals recently released from a correctional facility reintegrate into society and into health and social services
- ▶▶ To identify pre-release and recently released HIV+ individuals who are currently out of HIV care and to assist them in re-establishing their medical care

### POPULATION SERVED

- ▶▶ The primary target population is transgender (male-to-female and female-to-male) individuals soon to be released or recently released from a correctional facility.
- ▶▶ The secondary target population is gay, lesbian, and bisexual individuals who are soon to be released or recently released from a correctional facility.

### ACTIVITY DESCRIPTION

Transgender Post-Release Case Management offers support to transgender, gay, lesbian, and bisexual individuals living with HIV in establishing independence and health connections after release from incarceration.



QUICK NOTES:

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*“You have to prepare people to take control of their health. Until the client is ready, there’s not much you can do.”*

— DISCHARGE PLANNER

- ▶▶ A new case is initiated in one of two ways: 1) a correctional facility notifies the agency of an inmate who self identifies as, or is believed to be, transgender, gay, lesbian, or bisexual; or 2) a client contacts the agency after being discharged.
- ▶▶ The case manager, who is also a member of the primary target population, schedules an assessment appointment to determine whether the client is eligible for agency services.
- ▶▶ If the client is in a local correctional facility, the case manager can hold the meeting there, with the permission of the facility administration. If the client is in a distant facility, the case manager can talk with the inmate by phone about needed services. In either instance, the case manager informs the client of the agency’s service portfolio.
- ▶▶ In face-to-face meetings, the case manager’s demeanor and attitude communicate acceptance and non-judgment of the client, who may have experienced discrimination or abuse because of their appearance, behavior, or gender identification.
- ▶▶ Clients wishing to receive services sign a consent form granting permission for the release of information to the agency.

#### **Post-Release Meetings**

- ▶▶ Upon release, the client meets with the case manager at the agency, where s/he finds posters, signage, reading material, and other features to encourage cultural identification, safety and acceptance. At this first meeting, the client signs a formal “informed consent to release” allowing other agencies to help with establishing a continuum of care services.
- ▶▶ The case manager gathers intake information that includes emergency contacts, medical care history, known medical conditions, current medications, sources of income, and a breakdown of monthly expenses. The case manager also requests photo IDs, a birth certificate, release papers, the name of the parole officer and the terms of the client’s parole, if applicable.
- ▶▶ In the case of parole, the case manager may choose to inform the parole officer that the client is receiving services from the agency.
- ▶▶ The client and case manager do a behavioral risk assessment.
- ▶▶ After gathering the necessary information, the case manager and client develop a risk reduction plan. This plan includes safer sex goals, HIV risk reduction goals, and a list of needed support services. The client and case manager put together a comprehensive, 60-day life plan.
- ▶▶ Once satisfied with the plan, the client signs the document thereby committing to the plan.
- ▶▶ Depending on the information received from the client, referrals are made for specialized support services, general health care, mental health services, specialized health care, food banks, and social services.
- ▶▶ The case manager helps the client identify a medical provider and promptly schedules an appointment.
- ▶▶ The case manager then begins the task of completing an AIDS Drug Assistance Program application and a city health insurance application so that the client can initiate or re-initiate anti-retrovirals or HIV-related medications (assuming clinical assessments deem them necessary).
- ▶▶ This entire process takes four to five hours. The agency provides lunch to the client.
- ▶▶ On the following day, the client returns and receives copies of the completed paperwork.
- ▶▶ The case manager emphasizes to the client that the “ball is rolling” to get them the care they need.
- ▶▶ The case manager tracks progress by asking the client to call in after each appointment with a provider to report on the experience.
- ▶▶ If the client has no place to stay, the case manager helps to find emergency or transitional housing.
- ▶▶ After the 60-day life and service goals are met, the case manager establishes a meeting schedule consistent with the urgency of the client’s needs. The case manager also remains in touch with the client’s parole officer.
- ▶▶ The agency holds case management meetings to ensure that clients are receiving necessary services and to assess their progress in meeting goals.

## PROMOTION OF ACTIVITY

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- ▶ Outreach by community organizations
- ▶ Brochures distributed to correctional facilities
- ▶ Local media advertisements for the agency and the population served
- ▶ Advisory councils of people living with HIV
- ▶ Court referrals to agency
- ▶ Word of mouth

## II. LOGISTICS

### STAFF REQUIRED

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Two case managers who serve as discharge planners

### TRAINING & SKILLS

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Training in comprehensive cultural competency specific for this population

### PLACE OF ACTIVITY

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- ▶ A private office and drop-in area at the agency
- ▶ Meeting place in correctional facility

### FREQUENCY OF ACTIVITY

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As needed

### OUTSIDE CONSULTANTS

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Graphic design professionals to develop brochures

### SUPPORT SERVICES

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- ▶ Transportation vouchers
- ▶ Meals during long visits to the agency

### CONDITIONS NECESSARY FOR IMPLEMENTATION

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- ▶ Funding streams must be in place.
- ▶ Agency must have a strong working relationship with correctional facilities.

## III. STRENGTHS AND DIFFICULTIES

### STRENGTHS

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- ▶▶ Demonstrates to clients that the agency comes through with promised services
- ▶▶ Establishes and maintains trust with the client
- ▶▶ Creates a climate of support, understanding, and safety for clients
- ▶▶ The agency staff members are also members of the targeted population

### WEAKNESSES

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Clients may leave care and treatment because of substance use relapses or mental health problems.

### DIFFICULTIES FOR CLIENTS

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- ▶▶ Lack of transportation to appointments can be a serious barrier since transportation assistance does not cover non-medical appointments.
- ▶▶ It is difficult for some clients to obtain a government-issued identification card, and legal employment is impossible without it.

### DIFFICULTIES FOR STAFF

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- ▶▶ It is sometimes extremely difficult to maintain the “full attention” of a client when discussing health care needs—especially if that person has other pressing needs or priorities.
- ▶▶ Some clients do not take their care seriously.
- ▶▶ The substance use relapse rate is high.

### OBSTACLES FOR IMPLEMENTATION

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There is a documented gap in funding for services targeted to the transgender population.

### ACTIVITY NOT SUITED FOR

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The identified heterosexual population, severely mentally ill clients, and active substance users.

## IV. OUTCOMES

### EVALUATION

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- ▶▶ Case evaluations are managed through case management reports.
- ▶▶ The case supervisor monitors and tracks referrals through a database to determine the number of times per month a client accesses local services.
- ▶▶ Calls from clients at correctional facilities are logged.
- ▶▶ Client surveys provide feedback at different stages of service provision.
- ▶▶ The data from each annual report is compared to the data in past annual reports.

## EVIDENCE OF SUCCESS

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- ▶▶ Case management reports and referral monitoring show an increase in moving clients from post-release homelessness to independent living.
- ▶▶ Client tracking shows an increase in linking clients to HIV medical care.
- ▶▶ The number of clients served has increased over previous years.

## UNANTICIPATED BENEFITS

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Opens relationships between staff and criminal justice agencies, mental health agencies, and the police department

## “CONNECTING TO CARE” ELEMENTS OF ACTIVITY

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- ▶▶ The agency fills emergency needs first; the client feels cared for when assured they are not going to be homeless and that they will be linked to a full array of services.
- ▶▶ The message sent through the agency literature and promotion is that the agency “makes miracles happen every day.” Clients identify with that idea.
- ▶▶ The case manager is a mixture of compassion, personality, and patience.
- ▶▶ Clients understand that the case manager is serious about the work, and that all interventions will have follow-through.
- ▶▶ The service is explicitly client-centered.
- ▶▶ The case manager commits to clients with a willingness to go “the extra mile” and a spirit of compassion that wins clients’ confidence and trust.

## KEEP IN MIND...

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- ▶▶ It is important to have compassion and a mission to serve the transgender community.
- ▶▶ Moving people from homelessness to independent living is a key factor in getting and keeping transgender individuals in care.
- ▶▶ Focus on clients who demonstrate a serious desire to get and stay in care.



# What's Going on @ SPNS



AN UPDATE FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION,  
HIV/AIDS BUREAU, SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE

JANUARY 2012

## Improving Linkages and Access to Care

According to estimates from the U.S. Centers for Disease Control and Prevention (CDC), approximately 50,000 new HIV infections occur each year,<sup>1,2</sup> and an estimated 21 percent of infected persons are unaware of their serostatus.<sup>3</sup> The highest prevalence is in urban areas, where many people infected with or at high risk for HIV reside. In several major U.S. cities, seroprevalence rates exceed the 1 percent threshold that constitutes an epidemic. In Washington, DC, for example, 3 percent of residents are infected.<sup>4</sup> Seroprevalence rates among certain populations are even higher: African-Americans, Latinos, and men who have sex with men in particular have been hard hit by HIV/AIDS and represent “hard-to-reach” populations.<sup>5,6</sup> In some cases, entire States bear the disproportionate burden of HIV disease.<sup>2</sup>

People unaware of their serostatus are more likely to engage in risky health behaviors such as unprotected sex.<sup>7</sup> In fact, people living with HIV/AIDS (PLWHA) who are unaware of their status account for more than one-half of new infections.<sup>8</sup> Conversely, when people know their HIV status, they are less likely to pass on the disease, and studies show that patients on antiretroviral therapy (ART) are, in fact, less infectious.<sup>6</sup>

Lack of awareness can lead to advanced HIV disease: 35 to 45 percent of people with newly diagnosed HIV infection develop AIDS within 1 year after diagnosis, representing late entry into care. PLWHA who enter care at this point often have extremely compromised immune systems and AIDS-related complications.<sup>6</sup> These data underscore the need to more readily

- identify those with undiagnosed HIV,
- link persons who have tested positive for HIV into care,
- reconnect PLWHA who have dropped out of care, and
- retain patients in quality HIV care services (including access and adherence to ART).

A new Special Projects of National Significance (SPNS) initiative seeks to achieve those goals.

### Efforts to Increase HIV Testing and Linkage to Care

Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative (the Systems Linkages initiative) is an effort funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). The initiative funds seven Part B (States/U.S. Territories) Ryan White HIV/AIDS Program grantees for up to 4 years (2011–2015); the objective is to develop innovative and replicable systemic models of care. The initiative aims to improve linkages of PLWHA to necessary testing, treatment, and care services and is reflective of SPNS’ ability to evolve as the epidemic warrants and address increasing needs. This project in particular will have extensive reach and powerful implications as Demonstration States create and test models that could one day be implemented on a national scale.

Efforts to increase testing, however, are nothing new. In 2006, the CDC released testing recommendations seeking wider scale HIV testing (including screening for people ages 13 to 64 in all health settings),<sup>9,10</sup> and the Ryan White HIV/AIDS Treatment Extension Act of 2009 directed Part A and B grantees to seek early identification of PLWHA unaware of their status and link them to care.

HRSA’s AIDS Education and Training Centers offer technical assistance trainings to expand HIV testing and counseling in medical care settings and have reached more than 50,000 providers and conducted more than 3,100 trainings on Federal testing guidelines. Thanks in part to these trainings, more than 500 sites have implemented routine testing.<sup>11</sup> HRSA’s Bureau of Primary Health Care providers, who serve nearly 19 million patients in the Nation’s neediest communities, are also working toward the goal of increased testing.<sup>12</sup>

The relatively stable but high HIV incidence, however, calls for new strategies, including broader, more coordinated efforts across health care systems. To achieve this target, the 2011 Part B application guidance required grantees to describe their plans for addressing unmet needs for HIV-related services for PLWHA unaware of their status, and it required that grantees outline the steps they will take to implement those plans. To support Part B grantees in States heavily affected by HIV/AIDS, the System Linkages initiative will offer a new kind of capacity-building and shared-learning environment in which States will further integrate different components of their public health systems to work as one seamless unit.

“We’re not just going to have demonstration sites,” says Jessica Xavier, SPNS project officer, “but Demonstration States. So we’re not asking a single provider to implement these strategies, but entire States seeking to involve all of their HIV services organizations, along with some non-traditional organizations who can get involved in testing and referral to care.” Nontraditional organizations include community health centers, substance abuse clinics, mental health providers, hospitals, and outpatient medical clinics, all of whom, Xavier says, “have not traditionally had an HIV focus or done extensive HIV testing.”

Concurrently, the CDC is exploring complementary efforts at the city level with its Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project ([www.cdc.gov/hiv/strategy/echpp/index.htm](http://www.cdc.gov/hiv/strategy/echpp/index.htm)) in the 12 U.S. cities with the highest HIV prevalence. As Xavier explains, “CDC is focusing on cities, but it is also necessary to improve the coordination of services at the State level. That’s where HAB is filling the void, and this is all, of course, driven by the National HIV/AIDS Strategy.”

### The System Linkages Initiative and the National HIV/AIDS Strategy

The National HIV/AIDS Strategy, created by the White House Office of National AIDS Policy in collaboration with other Federal partners, calls for a combination of effective, evidence-based approaches along with targeted efforts and funding to populations and areas most in need. Achieving these ambitious goals requires strengthening HIV screening and surveillance activities and improving upon surveillance methods. It also necessitates the establishment of a seamless, continuous, and coordinated system that facilitates immediate linkages to care upon HIV diagnosis and strengthened retention efforts to better maintain patients in HIV primary care services.<sup>13</sup>

To best achieve the goals of the Systems Linkages initiative, grantees will be focusing on people unaware of their HIV status, defined as “any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result.”<sup>14</sup> Outreach to and engagement with people who do

## For More Information . . .

The SPNS staff and project officers working on the System Linkages initiative are

- Adan Cajina (301.443.3180; [acajina@hrsa.gov](mailto:acajina@hrsa.gov)),
- Pamela Belton (301.443.4461; [pbelton@hrsa.gov](mailto:pbelton@hrsa.gov)),
- Katherine Godesky (301.443.7874; [vgodesky@hrsa.gov](mailto:vgodesky@hrsa.gov)),
- Melinda Tinsley (301.443.3496; [mtinsley1@hrsa.gov](mailto:mtinsley1@hrsa.gov)), and
- Jessica Xavier (301.443.0833; [jxavier@hrsa.gov](mailto:jxavier@hrsa.gov)).

not know their HIV status are critical to the effort of curtailing HIV infections in our country.

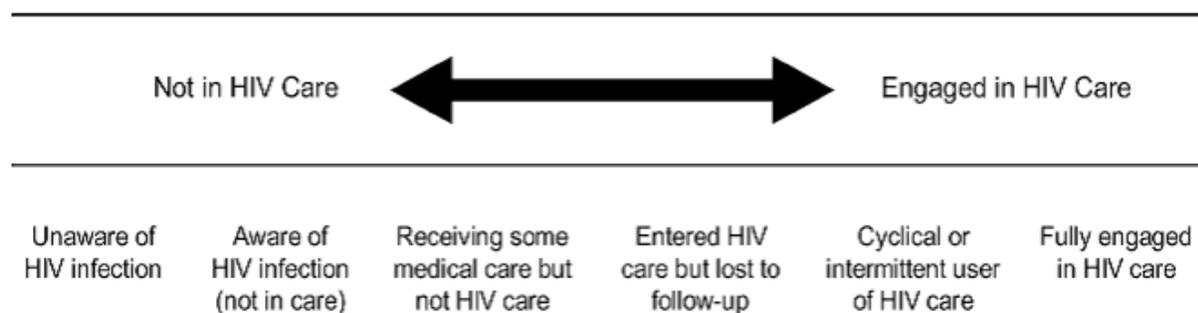
As the care continuum in Figure 1 illustrates, PLWHA may move from being fully engaged in care to sporadically or completely out of care; thus, efforts in this initiative also involve bringing patients back into care and keeping their viral load suppressed through the use of antiretroviral medications. “SPNS is always looking to identify innovative strategies, especially with the specific needs of the most affected subpopulations,” explains Katherine Godesky, SPNS project officer. So although this particular initiative is SPNS’ first statewide effort, Godesky says, “it didn’t really change what SPNS is all about. . . Part B grantees, however, have further reach so they can institute, replicate, and grow these interventions much further than what we’ve seen before.”

### Removing Barriers, Improving Care

The Institute of Medicine classifies barriers to accessing care into three categories: structural, financial, and personal/cultural.<sup>15</sup> SPNS has focused on these barriers previously and identified ways to overcome them and successfully link to and retain hard-to-reach populations in HIV primary care.<sup>16</sup> Where the Systems Linkages initiative differentiates itself is in applying lessons learned in a broad, State-level, cross-agency coordinated fashion.

As such, Demonstration States have to develop strategies to overcome structural barriers to accessing care, and they must leverage their existing funding and resources to work with key partners and stakeholders to integrate different components of their State’s public health system. These efforts will require sharing data to more accurately identify the number of new HIV cases in their area; assessing where target populations are located; and aggressively conducting HIV counseling, testing, and linkage to care for those populations.

To accomplish these goals, Demonstration States will adopt the Institute for Healthcare Improvement (IHI) Collaborative Model, which uses a team-based approach led by content experts. The experts serve as “faculty” and help organizations implement smaller scale changes, adapting or modifying as necessary, and

**Figure 1. Engagement in Care Continuum**

Source: HRSA. Outreach: engaging people in HIV care: summary of a HRSA/HAB 2005 consultation on linking PLWH into care. August 2006.

then slowly rolling out successful changes on a larger scale. This pilot-testing approach is known as “Plan-Do-Study-Act” (PDSA).

The Collaborative Model has been proven successful across other HRSA initiatives, and it allows grantees to make changes and test strategies in the planning phase before full adaptation across the State. “This is the first time SPNS is using the IHI model,” says Xavier, “but HAB has used this model previously for Title I [Part A] and Title III [Part C] and, most recently, in the cross-Part Quality Management collaborative efforts. This model has had traction and success, so we were asked to see if we could make these kinds of system-level partnerships work within a State.” Other selling points for the model include a focus on the necessary quality improvement strategies for testing and surveillance data.

To ensure success, the initiative’s evaluation center will offer technical and capacity-building assistance to Demonstration States throughout the course of the project. “We change from identifying small-scale interventions in Years 1 and 2,” says Godesky, “to expanding in Years 3 and 4 across the State.” In this way, Years 1 and 2 allow a kind of pilot project to identify any challenges, make adjustments, and re-execute launch before statewide rollout.

“The evaluation center will be conducting a lot of trainings throughout the initiative on PDSA cycle, counseling and testing, engagement and retention strategies, quality improvement, and capacity building,” adds Godesky. “The hope,” she says, “is that successful States will serve as a model for others. This initiative involves two States with cities participating in the CDC 12 Cities project, so it’s important for us to work closely with the CDC on this, as well.”

Godesky explains that it’s not just Federal agencies that must work together but all entities, large and small, in order to achieve all that the initiative sets out to do. “A lot of organizations work in silos,” explains Godesky, “and now we’re asking them to work to-

gether in their communities and across the State, representing an important and exciting time in public health.”

“Strengthening collaboration among Ryan White-funded grantees and providers is a long sought-after goal of HAB, and we do recognize that at a time when resources are increasingly limited, these kinds of partnerships are more important than ever before,” adds Xavier. “This initiative will create better care coordination and produce replicable models that will hopefully foster adaptations among other States not involved in the study.”

Looking ahead, Xavier says, “I think this initiative is representative of what’s to come: all Federal agencies moving forward to what’s outlined in the National HIV/AIDS Strategy and coming together to collaborate more frequently.” The end result? Curtailing HIV infections across the country and, ultimately, healthier Americans.

## Endnotes

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