OAKLAND TRANSITIONAL GRANT AREA STANDARDS OF CARE

Updated June 2026

Ryan White HIV/AIDS Program Services
Standards of Care

Contents

Universal Standards

INTRODUCTION:
As a recipient of Ryan White HIV/AIDS Program (RWHAP) funds, the Oakland Transitional Grant Area (TGA) must follow all laws and mandated policies that apply to the program, including the requirement that it must create and regularly update a local set of "Standards of Care" that covers each of the service categories for which it receives funding. Health Resources and Services Administration (HRSA) recommends revising the Standards of Care document every three years. However, it may be revised at any time. Since the RWHAP Standards of Care are based on federal requirements, this document must be updated as necessary to comply with changes in federal regulations.

The "**Universal Standards of Care**" outlined in this document apply to all RWHAP service categories. The Universal Standards are supplemented by a set of Standards of Care, each of which is unique to a specific service category. The Universal Standards form the foundational layer of requirements that must be followed regardless of service category. Specific Standards of Care, along with a set of Recommended Best Practices, define the program requirements that apply to each service category.

The Universal Standards spell out mandatory policies and practices that pertain to:

- Eligibility Procedures
- Program Characteristics, including Unallowable Costs
- Client Rights, Confidentiality and Security
- Client Consent
- Staffing, Training and Supervision
- Other Requirements
- Quality Assurance and Reporting
- Record Keeping, Administration and Financial Procedures
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In addition, administrators and staff of subrecipient agencies that receive RWHAP funds must follow, and work to enforce, all appropriate federal, state, county and city laws, policies, procedures, and other requirements aimed at guaranteeing clients safety, full access and fairness in services provided.

Eligibility Procedures

Subrecipient agencies must aim to provide services that are fully accessible and barrier free. Eligible clients must be able to access RWHAP services regardless of age, gender, sexual orientation, race, ethnicity, disability, income, geographical location of residence within the TGA, and other factors unrelated to qualification for services.

The primary intent of the RWHAP statute is to provide services to eligible clients living with HIV. As such, **RWHAP is always the payor of last resort. RWHAP funds may only be used for the HIV-related care, treatment, and support services needs of eligible individuals.** The Oakland TGA and its subrecipient agencies must be able to verify the eligibility of clients and/or affected individuals. If alternative payor options such as Medi-Cal, the Low Income Home Energy Assistance Program (LIHEAP), or other assistance programs are available, those options must be exhausted and documented in client records.

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To ensure the appropriate use of RWHAP funds, all clients must be evaluated for eligibility prior to the start of services. At enrollment, subrecipient agency staff must obtain **medical documentation of HIV status**. This documentation is to be kept in the client's record. Once HIV status is verified, providers *should not* request HIV documentation during future recertifications. Acceptable documentation includes the following:

- HIV positive lab results (antibody test, qualitative HIV detection test, or detectable viral load). Lab results with undetectable viral loads that do not indicate a positive HIV diagnosis will not be accepted during initial enrollment as proof of positive HIV diagnosis.
    - NOTE: Having positive results from only one HIV antibody test should not be a barrier to linkage to care to a RWHAP-funded clinic, or other HIV care providers, since the majority of people receiving a positive result from a single test have HIV infection and would benefit from quick linkage to ongoing care and prevention services
    - The receiving medical clinic must be informed of the individual's unconfirmed preliminary positive test result and the need for confirmation. RWHAP-funded clinics that receive such individuals may choose to arrange an abbreviated first appointment during which the individual receives counseling about HIV testing, baseline HIV genotypic drug resistance testing, and a limited evaluation that includes confirmatory HIV testing and potentially other HIV labs. (For more information, see the HHS *Dear Colleague Letter* dated February 25, 2013*).*
- A Letter of Diagnosis from the client's physician or licensed health care provider. Acceptable letters of diagnosis must be on the physician's or health care provider's letterhead and must include the physician's or provider's National Provider Identifier (NPI) number or California license number as well as the physician's or licensed health care provider's signature verifying the client's HIV status.
    - Letters that do not meet this standard but were already in client charts prior to April 1, 2018 will be accepted, but the above requirements for letters applies to new intakes conducted after April 1, 2018.
- Diagnosis Form (CDPH 8440) completed and signed by the client's physician or licensed health care provider. Any diagnosis form that contains pertinent information is also allowed.

Subrecipient agency staff must meet with the client to obtain **documentation related to ongoing eligibility** for RWHAP services, both at intake and on an annual basis for as long as the client receives services. This documentation is to be placed in the client's record. Examples of suitable documentation required **at intake** are as follows:

Proof of residence in the Oakland TGA includes:

- Copy of a signed lease with the client's name and address
- Copy of a current or previous month's utility bill or rent receipt with the client's name and address
- Copy of a Supplementary Security Income (SSI) benefits letter addressed to the client at their stated address
- Copy of a benefits letter from another public agency that is currently providing income to the client, addressed to the client at their stated address
- Notarized letter from a friend or family member, confirming the client's name and their address

- 'Verification of residence' letter on official letterhead confirming the client's placement in a shelter, transitional housing facility, residential treatment program or other similar housing facility/program or
- Client self-attestation that they are homeless or living in a temporary housing situation that cannot be documented.

Proof of annual income that is less than or equal to the current threshold based on the federal poverty level (FPL), including but not limited to:

- Copies of current pay stub(s) with the client's name and year-to-date gross income. For clients whose employment is temporary, part-time or seasonal, subrecipient agency staff should request a sufficient number of pay stubs to obtain an accurate estimate of annual income that takes fluctuations in income into account
- Copy of the client's most recent W-2 form
- Copy of the client's benefits letter from the Social Security Administration, County Social Services Agency (SSA), Veterans Administration, State Employment Development Department or other equivalent agency providing income support
- Signed and notarized letter from a person providing the client with financial support, including the amount and frequency of support payments
- Proof of active Medi-Cal benefits
- Bank statement showing direct deposit of Unemployment Insurance or SSI/SSDI benefits; the statement must be dated within one month and clearly identify the deposit/income source (e.g., US Treasury, SSA, etc.)
- Client self-attestation that they have no income or that their income cannot be documented (e.g., day labor)

An assessment of the client's third-party payor capacity, including but not limited to:

- Copy of the client's insurance card
- Copy of report obtained from the Medi-Cal eligibility system, with the name of the subrecipient agency staff who verified the client's status and the date that the status report was obtained
- Verification obtained from a private insurance company, with the name of the subrecipient agency staff who verified the client's status and the date that the verification was obtained or
- Client self-attestation of uninsured status

If the Case Manager or other program staff are not sure whether the available documentation is acceptable to demonstrate eligibility, they should contact their Office of HIV Care Program Manager for clarification or consideration of alternative documentation.

"Affected" individuals, i.e., individuals who are not living with HIV, may be eligible to receive RWHAP services in limited situations; however, these services must always provide a defined benefit to a named individual who is living with HIV. Eligibility must be documented with respect to the relationship between the "affected

individual" and the person living with HIV, the type of support the affected individual intends to provide, and the benefit to the person living with HIV. Circumstances under which affected individuals may receive services paid with RWHAP funds are:

- Services for which the primary purpose is to enable the affected individual to directly care for someone living with HIV
- Services through which a person living with HIV can receive necessary medical or support services by removing an identified barrier to care
- Services that promote family stability for managing the unique challenges created by a family member who is living with HIV

To maintain eligibility for RWHAP services, clients must be recertified annually. The primary purpose of **recertification** is to confirm that the individual's residence, income and insurance status continue to meet program eligibility requirements, and to verify that the RWHAP is the payor of last resort. At recertification, the subrecipient agency may choose to require a full application along with associated documentation of income and residence. As an alternative, the subrecipient agency may use client self-attestations of "change" or "no change." A self-attestation of a change must be accompanied by documentation of any change in eligibility status. (HIV/AIDS Bureau Policy Clarification 13-02, Required Documentation Table)

Program Characteristics

It is not expected that newly contracted organizations be in full compliance with the Universal Standards of Care – and the Standards of Care for each category – at the time of the initial contract execution. It is expected, however, that newly contracted service providers read and understand these standards. By signing a contract, the provider agrees to make every effort to progress toward full compliance with these standards within the contract year The only exception is that staff must possess the minimum qualifications required as described in the relevant Standard of Care.

A. **Programs must be equitable, inclusive, and culturally competent.**

B. **Programs must provide low-barrier and safe access to care** in an environment in which a person or category of people can feel confident that they will not be exposed to discrimination, criticism, harassment, or other emotional or physical harm. The program should be welcoming to all clients, especially those whose past experiences may have created mistrust of the healthcare system.

C. **Services must be provided in the client's primary language.** If that language is not English, translation services must be provided by a staff member or by other means.

   - Subrecipient agencies should advertise the availability of translation services.
   - Subrecipient agency staff must be trained in the use of translation services.
   - Where feasible, information about services, policies and program procedures should be given to clients in their preferred language.
   - Information given to clients or posted for viewing should be available in English and in each of the OTGA's local threshold languages.

D. **The RWHAP is the payor of last resort.** The following costs are never allowable under the provisions of the RWHAP and may not be paid using RWHAP funds. (This is not a complete list, and payment for

other services may not be approvable).

- Cash payments to clients
- General use pre-paid cards, i.e., Visa gift cards or gift cards for a related group of merchants that are general use and not dedicated to a particular store
- Clothing purchases
- Employment and employment-readiness services
- Funeral and burial expenses
- Property taxes owed by a client

E. **Up to 10% of RWHAP funds may be used by subrecipient agencies for administrative support** of the services. The remaining 90% must go directly to direct client services.

Across the TGA, total RWHAP funds must be distributed with **75% reserved for core medical services and 25% allowed for support services**, unless a waiver is obtained**.** As of 2026, services funded within the Oakland TGA include the following categories:

CORE MEDICAL SERVICES	**SUPPORT SERVICES**
Early Intervention Services	Child Care Services
Home & Community-Based Health Services	Emergency Financial Assistance
Medical Case Management Services	Food Bank/Home-Delivered Meals
Medical Nutrition Therapy	Health Education/Risk Reduction
Mental Health Services	Linguistic Services
Oral Health Care	Medical Transportation
Outpatient/Ambulatory Health Services	Non-Medical Case Management
Substance Abuse Outpatient Care	Other Professional Services (including Legal Services)
	Outreach Services
	Referral for Services
	Psychosocial Support Services

Client Rights, Confidentiality, and Security

Client rights and confidentiality standards are critical to the provision of RWHAP services.
To ensure that client rights and confidentiality are respected at all times, each agency providing RWHAP services must have evidence of the following written agency policies:

- A written agency policy about the transmission, maintenance and security of medical information which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including agency-specific procedures for release of information
- A written agency policy on client confidentiality, available on request
- A written agency policy on the security of client records, including but not limited to: how staff access to records is restricted (e.g., secured areas for records storage and locking filing cabinets), and procedures for implementing the use of encryption, password protection, and secure processes for

backing up of electronic records.

In addition, all subrecipient agencies providing RWHAP services must ensure that client confidentiality is protected through the use of letterhead stationery, business cards, agency forms, prescription and transportation vouchers, etc. that do not reveal that the agency provides HIV-related services. Communication via email (including information in email signatures) or by phone (e.g., outgoing voicemail messages) must provide the same confidentiality protections. Email communication containing client information should be encrypted.

Each subrecipient agency providing RWHAP Services must also maintain records of staff training to ensure that all agency staff, volunteers, and subcontractors have been oriented to the above policies and procedures and have agreed to follow them.

Consent

Before any services begin, all appropriate consent forms must be signed and dated by the new client. Copies of all consent forms must be given to the client, with copies filed in their record. California laws regarding confidentiality and client consent (CA Civil Code Section 56.10 – 56.16 and CA Health and Safety Code, sections 120975-121020) must be followed.

Consent forms must include language that allows clients to verify that:

- They received a copy of all program policies relevant to the services they will receive.
- They received a copy of the agency/provider's statement regarding client rights and responsibilities, including the confidentiality policy and the agency grievance policy.
- They understand the agency's policies related to release and exchange of information, **including that HIV molecular sequence data is reported to the CDPH to assist in public health monitoring of transmission patterns and rapid cluster response.**.

In addition to other forms, a signed and dated Client Consent Form must be on record for all clients receiving RWHAP services.

Staffing, Training, and Supervision

Personnel standards are designed to ensure that all professionals providing HIV/AIDS services in the Oakland TGA are properly trained and licensed as required by state law, that they have an understanding of the scope of their job responsibilities, and that all funded programs are properly staffed. To this end:

Hiring: Hiring practices must comply with all relevant federal, state and local laws regarding equal opportunity in employment.

Position descriptions: All positions, whether for salaried, hourly or volunteer staff, must have written job descriptions detailing job duties and minimum qualifications.

Performance review: Supervisors must conduct an annual performance review for all employees and volunteers, with the written results of the review included in the employee/volunteer file.

Licensing: All staff that provide RWHAP services and whose positions require licensure must possess appropriate licenses and expertise as defined in the service-specific Standard of Care. Documentation of the individual's license and relevant experience must be kept on file.

Supervision and Oversight: Subrecipient agencies are required to provide regular supervision to RWHAP staff and volunteers to ensure ethical and competent services, to provide support for managing client issues, and to ensure that the Standards of Care are followed. Supervision meetings will be led by staff with appropriate credentials and supervisory experience. Supervision meetings should ideally take place at least once a month and should be documented in agency files.

Note: All intern/associate clinicians and students must be supervised by appropriately licensed professionals in accordance with the standards of their governing board.

Training and Continuing Education: Written documentation of trainings and continuing education activities must be kept on file for each staff person and volunteer as appropriate. All staff that provide RWHAP services must receive initial as well as updated training at least once a year in the following areas:

- Updates related to HIV/AIDS, transmission, treatment, virologic suppression, **interpretation of HIV genotype results, the clinical and public health role of cluster detection,** or other issues
- Review of current agency policies, procedures and service standards
- Cultural humility, including the promotion of sex positivity, the importance of trauma-informed care, and the impact of HIV stigma, transphobia and homophobia
- Linguistic appropriateness for all services, including the avoidance of stigmatizing, homophobic and transphobic language
- Available options for disabled service access or language accessibility, including information about current agency policies for provision of, or referral to, interpreters, translated materials, native speakers on staff, cultural awareness training for staff, or other guidelines for language accessibility
- Bloodborne pathogen exposure, universal precautions, and employee tuberculosis (TB) screening policy
- HIPAA compliance and other confidentiality protections

Clinical record review: Supervisors must conduct client records reviews on a regular basis (at least every 6 months) to assess staff's documentation of client eligibility and other relevant issues. The records review should include a record of corrective actions to be taken if deemed appropriate.

Other Requirements

In addition to the standards described in the preceding sections, there are a number of other requirements that all subrecipient agencies and staff providing services under the RWHAP must follow.

Community referrals: Subrecipient agencies providing services under the RWHAP must maintain an updated list of community resources and distribute this list to staff, clients, and families as appropriate. These lists need not be created from scratch; agencies are encouraged to share resources with other organizations where possible, including the Alameda County Public Health Department, Contra Costa Health Services, East Bay Getting to Zero, the Oakland TGA Planning Council and other community agencies. The creation and sharing of these lists minimizes duplication of efforts, ensures that client services are provided in partnership

with other programs and HIV service providers, and fosters client access to integrated health care.

Documentation of referrals: Subrecipient agencies providing RWHAP services must implement and maintain a method for tracking referrals. If referrals are not used by clients, the service provider should have a procedure for contacting the client to follow up on the referral.

Coordination of care: Subrecipient agencies must establish internal and external relationships in order to develop programs, policies, and referral opportunities and strengthen linkage to care. Whenever possible, these relationships should be formalized through Memoranda of Understanding (MOUs) or other types of documentation. Agency policies should ensure that clients are linked to primary care quickly and in a way that encourages a strong connection with the primary care provider. Special attention must be given to supporting the needs of formerly incarcerated individuals who are re-entering the community.

Access to Specialists: Subrecipient agency administrators must work to establish linkages with key specialists to ensure that primary care providers and other service program staff have access to expert support as needed.

Involvement of clients in their care: To improve the quality and effectiveness of care, subrecipient agencies must encourage client involvement in their treatment. Client involvement in treatment planning and service delivery must be demonstrated as follows:

- A client signature is required on each treatment plan developed in concert with their provider
- All clients must be invited to participate in the Office of HIV Care's annual consumer satisfaction survey regarding their care
- Subrecipient agencies must complete a written summary of consumer satisfaction survey findings, along with a detailed corrective action plan to address shortcomings identified in the survey.

Grievance Procedure: Clients have the right to file a grievance or complaint if they are not satisfied with the RWHAP services they have received. Subrecipient agencies must post a copy of their agency's grievance procedure in a public area such as a waiting room, provide the client with a copy of the grievance procedure during the intake interview, and obtain the client's signature acknowledging receipt of the grievance procedure. The agency grievance procedure must include specific details describing how a client can file a grievance, what steps will be taken after the grievance is filed, and how the agency will take steps to protect the rights and quality of treatment of the client after a grievance has been filed. RWHAP legislation requires that subrecipient agency grievance procedures must conform to grievance procedure requirements outlined in the Public Health Service Act, Title XXVI, §2602(c)(2).[1]

The Oakland TGA Client Grievance Policy is designed to provide a mechanism for report and resolution of **unresolved** issues related to services provided by the subrecipient agency. This Client Grievance Policy defines the particulars regarding who should be contacted, how to document the concern, the timeline for expectation of response, and follow-through in instances where a satisfactory resolution has not been established.

All complaints should initially be brought to the attention of the leadership of the subrecipient agency, in

[1] Public Health Service Act, Title XXVI, §2602(c)(2).

accordance with the subrecipient agency's grievance procedure. If the informal dispute resolution at the subrecipient agency level has been unsuccessful and the client wishes to appeal the subrecipient agency's decision, the client must follow the Oakland TGA Client Grievance Policy and submit a written appeal of the subrecipient agency's decision to the Alameda County Public Health Department, Office of HIV Care within ten (10) business days of the event or occurrence that prompted the grievance.

The appeal request must include the following documents:

- An "Office of HIV Care Client Grievance Appeal Form" signed by the client
- Copies of all documents related to the client's original complaint and subsequent meetings with subrecipient staff
- A copy of the final written decision issued by the subrecipient agency and
- An "Office of HIV Care Client Grievance Authorization to Release Information", signed by the client.

Client Grievance Form (PDF-English)
Client Grievance Form (PDF-Spanish)

Client Grievance Authorization to Release Information Form (PDF-English)
Client Grievance Authorization to Release Information Form (PDF-Spanish)

Program Site and Location Standards: These standards are intended to ensure low-barrier accessibility to care for clients, as well as program safety for both clients and staff. The subrecipient agency's clinic(s) or program site(s) should be located in an area that is as safe as possible. Services must be delivered at a secure location with posted hours of operation. The clinic(s) or program site(s) must have private, confidential space for clients to meet with program staff, and bathrooms should be located near offices. Subrecipient agencies must comply with city and/or county fire regulations, and the site should be fully compliant with local building codes, zoning laws, and health and safety regulations, including clearly visible emergency exits, smoke detectors, and carbon monoxide detectors.
Ideally, services should be provided at locations that are easily accessible via public transportation. Agencies should have visual evidence of wheelchair access where appropriate.

Quality Assurance and Reporting

In order to ensure that people living with HIV in the Oakland TGA receive the highest quality of care and services, to assist medical service providers in ensuring that services adhere to best clinical practices and guidelines, and to promote continued quality improvement, the OTGA has established the following standards:

A. Subrecipient agencies who provide service categories that are utilized by 15% or more of RWHAP eligible clients in the Oakland TGA must have a written Quality Management Plan. Agencies will be informed by the Office of HIV Care if one or more of their funded service categories are subject to this requirement. Each agency's plan must include a description of the tools used to measure program outcomes, methods for data collection and storage, and how data will be used to improve the program.

B. Subrecipient agencies must have data reporting capabilities that are adequate to meet expected reporting deadlines.

C. All subrecipient agencies will be monitored by the Recipient, with a minimum of one formal site visit conducted each fiscal year. Subrecipients who subcontract direct services similarly must monitor subcontractors, with at least one formal site visit annually. This visit is for the purpose of ensuring compliance with contracted requirements, evaluating program effectiveness and providing technical assistance. The agency will be provided a summary of any reports prepared as a result of the visit. Compliance will be reviewed in the following areas:

   a. Appropriate documentation of client eligibility for RWHAP services in the client record

   b. Within the record, documentation of contacts and services that is consistent with the units of service and unduplicated client counts that are reported through routine data reporting mechanisms

   c. Accurate invoicing for services provided

   d. Documentation related to requests and/or needs for technical assistance from the Alameda County Public Health Department, HRSA, the CDC, or specialized Capacity-Building Assistance (CBA) organizations and

   e. Any other forms or documentation that are required by the RWHAP Universal Monitoring Standards.

Record Keeping, Administration, and Financial Procedures

Subrecipient agencies are responsible for documenting and maintaining accurate records of service-related health outcomes and units of service, as required for reimbursement of service expenses.

- Accepted guidelines related to health care documentation practices and record-handling should be followed.
- Records should be available only to agency staff who are directly responsible for filing, charting and reviewing, and to OTGA, State and Federal representatives as required by law.
- All signed documents must be secured in the record and protected from potential damage for as long as it is required under California law.
- Agencies must maintain confidentiality for computer files, including appropriate safeguards such as encryption and password protection, with access limited to designated personnel.
- Paper files must be kept in secure, locked cabinets in locked rooms, with access limited to designated personnel.
- Each client receiving RWHAP services must have a separate client record and unique identifying number. Records must follow a standard format, with standardized documents
- Documentation must be legible, computer-generated, or handwritten in ink. Documentation must be dated and signed by the staff responsible when applicable.

To ensure RWHAP funds are funds of last resort, agencies must maintain fiscal integrity by using:

- Generally accepted accounting principles
- Annual independent audit or review according to funding-level requirements
- Internal control policies and procedures and
- Cost principles for non-profit organizations (per OMB circular A-122)

Agencies may not request reimbursement higher than the cost per unit of service that is negotiated with the Oakland TGA.

Agencies must submit annual audit reports and agree to fiscal site visits upon request. At these visits, agencies must be able to demonstrate accurate invoicing, an appropriate system in place to track the RWHAP funding separately from other funding sources, and the agreement of the general ledger with the final program invoices.

Early Intervention Services – Core Service

INTRODUCTION:
This document describes the requirements and standards that apply to the "Early Intervention Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Early Intervention Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the service definition and program requirements.

SERVICE DEFINITION:
The purpose of RWHAP Part A Early Intervention Services (EIS) is to support comprehensive primary health care and support services in an outpatient setting for low-income, uninsured, and underserved people with HIV with a goal of improving health outcomes. Early Intervention Services include:

- Counseling individuals about HIV/AIDS
- Focused HIV testing, including tests to confirm the presence of the infection **and baseline HIV genotypic drug resistance testing (ideally within 90 days of diagnosis)**, to diagnose the extent of immune deficiency, and to determine appropriate therapies
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services, such as Outpatient/Ambulatory Health Services, Medical Case Management and Substance Abuse Outpatient Services and RWHAP Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

These services are meant to actively reach into the community to identify people at the earliest point in their diagnosis of HIV disease. Early Intervention Services offer information, referrals and treatment to help individuals engage in medical care and to facilitate access to other services as necessary to help them maintain themselves in medical care.

The elements of EIS often overlap with other service category descriptions. EIS is designed to be a combination of such services rather than a stand-alone service.

PROGRAM REQUIREMENTS:
All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to adhere to the following standards:

SERVICE COMPONENTS:
Subrecipient agencies that offer Early Intervention Services must include the following four components, either through direct provision or through linkage to another provider who offers the service:

1. **Focused HIV Testing:** This component is designed to help those who do not know their HIV status learn whether they are living with HIV and receive referrals to HIV care and treatment services if they are diagnosed with HIV.
    a) EIS providers must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of effort.

b) HIV testing paid for by EIS cannot take the place of testing efforts paid for by other sources, as RWHAP is always the payor of last resort.

c) Individuals who test positive must be referred to, and linked with, health care and supportive services within 30 days of diagnosis.

2. **Referral services for health care and support services:** This component is designed to improve HIV care and treatment at key points of entry. Building strong relationships with care and treatment providers who are able to quickly see new patients is critical to success.

3. **Access and linkage to HIV care and treatment services:** This component is designed to ease connection to Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Outpatient Services. Clear linkage procedures are required to encourage the integration of these service categories, and linkage agreements should be formalized in written MOUs when possible. Agencies funded for EIS should work with local emergency departments to support linkage to care for clients diagnosed in those settings.

4. **Outreach Services and Health Education/Risk Reduction:** This component is intended to identify those who do not know their HIV status but are at high risk of HIV infection, as well as those who know they are living with HIV but are not yet engaged in care. Services should include health education and literacy training that enables clients to navigate the HIV system, healthcare system, and should be provided in coordination with HIV prevention efforts and programs that provide HIV prevention services. This component should also include partner services.

SERVICE CHARACTERISTICS

Eligibility: Unlike almost all RWHAP services, some EIS services are offered without eligibility determination. These services, which include initial HIV testing, traditional outreach services, and some referral services, are provided for a limited time and are meant to link those who test positive, or who have a positive HIV status, to longer-term services where eligibility and full assessment services are conducted. Contacts between the outreach worker and the individual should be recorded on an encounter form along with brief statements assessing the person's immediate needs and the plan for meeting those needs.

Tools: The strategies that are used to draw people into service may be different from those that are designed to keep them engaged and participating in care. It is intended that individuals will progress from early and intensive service utilization and will assume more self-management and self-reliance with the transition from EIS services to ongoing or continued services. However, EIS does provide continued services through the medical services described in the definition.

Outreach: Outreach is a critical part of this service category. Outreach and recruitment activities identify and recruit those who are at highest risk of falling out of care. Use of an assessment tool to identify people at highest risk is important, as is ensuring that outreach workers are able to establish trust and communication with the populations whose histories put them at highest risk for not engaging in care.

Partner Services: Partner Services (including third party notification) is another critical service to be offered at the same time as EIS, to help prevent further spread of infection.

Core Performance Measures:

Linkage to Care	Was the client linked or relinked to care in 30 days or less?
Rapid ART	Was the client prescribed ART at their first medical visit?
Retention in Care	Did the client have 2 medical visits at least 90 days apart in the last 12 months?
Viral Suppression	Did the client reach an HIV viral load of <200 copies/mL?

RECOMMENDED BEST PRACTICES:
Training: EIS staff should be trained in the use of a trauma-informed perspective and should have a strong understanding of the barriers to care and possible strategies for reducing barriers among the highest-risk clients. Staff who do not already have this knowledge and experience should be encouraged to participate in training or other continuing education activities.

Engagement and Retention: Agencies are strongly encouraged to develop and maintain a strong, standardized protocol for engaging and retaining clients during outreach and testing activities, as those clients most likely to benefit from EIS are also those who are most difficult to retain in ongoing services, linkage, and follow-up.

Emergency Financial Assistance – Support Service

INTRODUCTION:
This document describes the requirements and standards that apply to the "Emergency Financial Assistance" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Emergency Financial Assistance must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION:
Emergency Financial Assistance (EFA) consists of limited financial assistance that is designed to address a client's emergency need for support in paying for rent, essential utilities and food. When medically necessary, EFA can also be used to pay for the short-term rental of hotel/motel rooms. The cost of transportation, medications and dental care may also be covered by EFA if an alternative source of payment is not available.

The HRSA HIV/AIDS Bureau issued a program letter dated June 26, 2024 announcing a national policy change that would provide recipient agencies with the option of using RWHAP EFA funds "to pay for a RWHAP client's security deposit if a RWHAP recipient or subrecipient has policies and procedures in place to ensure that the security deposit is returned to the RWHAP recipient or subrecipient and not to the RWHAP client."

PURPOSE/GOALS:
The goals of Emergency Financial Assistance are to:

- Stabilize the client's life circumstances through one-time, short-term assistance
- Engage and retain the client in treatment and care
- Enable access to medical care
- Improve the client's quality of life and health and
- Move the client toward self-sufficiency.

REQUIREMENTS:
All subrecipient agencies receiving funds to provide financial assistance under this RWHAP service category are required to adhere to the following standards:

- The use of RWHAP-funded EFA is always subject to payor of last resort requirements, i.e. EFA funds must only be used when other sources of assistance cannot be found.
- The subrecipient agency must have written policies to standardize the distribution of benefits.
- The subrecipient agency must establish an annual per person cap, for the RWHAP program year, based on available funds and prior year utilization that clearly states the maximum amount of assistance a client may receive and the number of times that assistance can be requested and granted.
- Clients seeking assistance must be actively engage with agency staff (ideally a medical case manager) to ensure their need for EFA is assessed and they are supported to address financial challenges

moving forward.

- Requests for emergency assistance, including documentation of the nature of the emergency, must be made in writing using a standard application form that is signed by the client and medical case manager or other designated staff from the client's primary agency. All documentation related to the EFA request must be maintained in the client's record. If it is the subrecipient agency's policy to require a consent form specifically for the receipt of emergency financial assistance, a copy of the consent form must also be maintained in the client's record.
- Subrecipient agencies must take all necessary steps to ensure that application forms, letters to payees, informational flyers that describe program eligibility criteria, and other materials are written in such a way that the source of funding is kept strictly confidential, and that clients seeking EFA funds are never identified as people living with HIV.

PROCESS AND DOCUMENTATION – Unpaid rent and essential utility costs:
The following requirements apply specifically to the use of EFA funds for unpaid rent and essential utility costs:

- RWHAP EFA is not designed to be used as an ongoing subsidy.
- Subrecipient agencies must have the ability to respond to client requests for Emergency Financial Assistance within 3-5 business days.
- Payments for delinquent rent and unpaid utility costs (gas, electricity, water and sewer, and garbage collection) must be limited to situations of critical financial need, e.g., when the client's housing and/or utilities are in immediate danger of being lost as a result of non-payment.
- The request for rental assistance must be accompanied by the housing provider's written statement of the monthly rent amount and the amount of delinquent rent owed.
- Written verification (e.g. court documents or notices to vacate) must be provided if the client is in the process of being evicted.
- Housing providers must confirm in writing that the receipt of EFA funds will allow the client to stay housed for at least 30 days.
- Information from housing providers must be provided on agency/company letterhead or forms. Emails and notes or letters on non-letterhead paper will not be accepted.
- Emergency financial assistance is not to be used to cover current and/or future costs of rent and utilities.
- Subrecipient agencies may never make payments directly to clients. Payments must be made directly to the housing provider or public utility agency.
- Subrecipient agencies must be provided with documentation of the housing provider's identity and contact information, along with a completed IRS Form W-9 signed and dated by the housing provider within 12 months of the date of the EFA application. The payee name on the check made payable to the housing provider must match the name on the IRS Form W-9.
- EFA may be used to pay delinquent rent on a room rental, but the primary tenant (the individual to whom rent is paid) must furnish a current IRS Form W-9 and must be informed that they will receive an IRS Form 1099 reporting the EFA payment as income.

- In the case of delinquent utility payments, the most recent bill must be provided by the client, and must include the current balance, prior month(s) balance and the name of the account holder.
- The client's case manager is responsible for completing the application for EFA and for communicating with the housing provider.

PROCESS AND DOCUMENTATION – Emergency food assistance
The following requirements apply specifically to the use of EFA funds for food assistance:

- Food assistance may be provided in the form of grocery vouchers (supermarket gift cards) or access to food banks.
- Medical case managers or other designated agency staff must review and approve the client's request for food assistance. Documentation of the client's request for assistance must be maintained in the client's record.
- The client's medical case manager or other designated agency staff member is responsible for documenting dates and amounts of food gift cards or vouchers distributed.
- Subrecipient agencies must store the gift cards in a secure location and maintain a record-keeping system such as a log that includes the gift card serial number, the date the card was issued, and the name of the client receiving the gift card.

PROCESS AND DOCUMENTATION – Transportation
The following requirements apply specifically to the use of EFA funds for transportation:

- Transportation assistance can be used to cover the cost of paratransit transportation.
- Transportation cards that cover the cost of multiple rides must be stored in a secure location and the subrecipient agency must maintain a record-keeping system that includes the gift card serial number, the date the card was issued, and the name of the client receiving the gift card.
- The client's medical case manager or other designated agency staff member is responsible for documenting dates and amounts of transportation cards or vouchers distributed.

RECOMMENDED BEST PRACTICES:
Subrecipient agencies that provide medical case management services should consider implementing the following practices:

- Supporting the client in developing a monthly budget, as is required by the Housing Opportunities for Persons with AIDS (HOPWA) Short-Term, Rental, Mortgage & Utility Assistance (STRMU) program, and should help the client to identify strategies to reduce non-essential expenses.
- Asking the client how much they can afford to pay toward their unpaid rent and/or utility costs, and encouraging the client to enter into payment agreements if possible.
- Developing a housing stability plan that will be incorporated into the client's care/treatment plan and reviewed on a regular basis.
- Offering workshops or individual training in budgeting/money management.

Food Bank / Home Delivered Meals – Support Service

INTRODUCTION
This document describes the "Food Bank / Home Delivered Meals" category of support services under the Subrecipient agencies that receive RWHAP funds to provide the Food Bank / Home Delivered Meals must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category.. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION
Agencies funded under the Food Bank / Home Delivered Meals service category provide actual food or meals. The service category does not allow the provision of cash or alternative methods of payment for the client's access to food or meals. Providing essential household supplies such as personal hygiene items, household-cleaning supplies, and water filtration/purification devices is also included within this category, when the subrecipient's budget allows and/or items are donated.

REQUIREMENTS
All service providers receiving funds under this RWHAP service category are required to adhere to the following standards:

- **Staff Training:** All staff directly involved in food service provision must be trained in safe food handling practices.
- **Priority Clients:** Providers must ensure that clients with the greatest need are able to access food services and congregate meals.
- **Resources and Referrals:** Providers must have a list of alternate food service resources and referrals available for clients.
- **Quality:** Providers must provide healthy and balanced meals according to U.S, Dietary Guidelines.

INTAKE AND ELIGIBILITY

- **Referral:** Clients must be referred to Food Bank / Home Delivered Meals services by their medical case manager or primary care provider.
    - **Payor of Last Resort:** Food must be provided using Medi-Cal waivers or other payers when possible, utilizing RWHAP resources only as a payor of last resort.
- **Intake:** Upon referral, clients must first complete an intake and assessment before receiving food through a food bank or home delivery. The assessment must include examination of the following:
    - Medical considerations (HIV status/prognosis and other conditions)
    - Food allergies
    - Medicine and food interactions
    - Dietary restrictions

  - Food preferences
  - Nutritional supplements
  - Food preparation ability, including whether the client possesses a microwave, stove, refrigerator, utensils, working utilities, and/or cooking skills.
- After assessment, an individualized meal plan must be developed by the intake staff and reviewed by a registered dietician (if the person performing the intake is not a registered dietician).
  - Whenever necessary, meal plans must include:
    - Options for soft and/or liquid foods with extra portions
    - Special diets for diagnostic testing
    - Extra fluid needs to avoid dehydration and diarrhea
    - Supplements for wasting syndrome, if applicable.
  - This plan must be signed by both the client and the provider and maintained in the client file.
  - Meal plans must be shared and coordinated with the client's case manager and/or primary medical care provider.

CONTINUING SERVICES

- All services within this service category must be delivered confidentially. Those who prepare, deliver, serve, and distribute food must be trained in how to protect confidentiality, especially when services are provided to clients in their home.
- Clients' individualized meal plans must be re-evaluated at least every 6 months, or more often depending on the health status of the client.
- The Food Bank / Home Delivered Meals provider is responsible for ensuring that clients receive all deliveries of meals or groceries as long as they are receiving the service.
- When applicable, the delivery staff is responsible for reporting to the agency any changes in service delivery plans (e.g. if they are unable to deliver three consecutive meals).
- If any change in the service plan is indicated, the provider must follow up with the client and/or referring agency to determine next steps regarding the changes.

FOOD BANKS

- Food banks distribute safe and nutritious food, groceries, and nutritional supplements, including liquid supplements.
- Food must be distributed to clients in pre-packaged boxes according to their written meal plans, developed under the supervision of a licensed nutritionist or registered dietician.
- Clients with meal plans may pick food up at the food bank two times per month or arrange for home delivery (see *Home Delivered Meals section below*).

HOME DELIVERED MEALS

- If it is determined to be necessary during intake/assessment procedures, home delivery of food may be provided.
- Home-delivered food must be distributed to clients in pre-packaged boxes and meet the needs of the written meal plans, developed under the supervision of a licensed nutritionist / registered dietician.
- Home delivery of food must be consistent, reliable, and offered on a flexible schedule in order to meet the needs of the client (i.e., various times and days for delivery).
    - Delivery at a consistent day and time by the same driver builds a relationship between the client and the driver, helps ensure successful delivery, and improves the sense of respect and community belonging for the client.
- If it is medically necessary, up to one meal per day may be delivered hot. In other cases, meals are delivered frozen (up to 7 days of food at a time) or as groceries for client preparation (delivered twice per month).
- Food that is delivered to clients' homes must include instructions about how to properly reheat or cook the food and maintain food safety.

RECOMMENDED BEST PRACTICES

GENERAL SERVICES CHARACTERISTICS TO BE OFFERED WHENEVER POSSIBLE

- Providers should be accessible by public transportation or medical van.
- Agencies providing Food Bank / Home Delivered Meals services within the TGA are encouraged to collaborate whenever possible, in order to provide consistent quality and quantity of food offerings for clients.
- Variety and options should be offered when possible, including culturally appropriate food offerings, to be accessed according to the client's choice.
- Agencies providing food through this service category are encouraged to implement a mechanism client feedback to monitor client satisfaction and continuous quality management.
- Food provisions should include easy recipes for clients to follow and all the ingredients necessary for the client to properly prepare meals, including spices/seasonings/herbs. The goal is to provide "everything you need" boxes that are self-contained and easy to turn into complete meals.
- At the time food is furnished/delivered, also supply a reference page that provides information about where clients can obtain other foods at low to no cost, when they find that the food provided in the box is insufficient for their needs.
- An extra, optional offering along with the provision of food is nutritionist-organized cooking demos, particularly highlighting new foods, and cooking with limited kitchens (in SROs, with microwaves, etc.). These types of activities not only improve clients'
- ability to prepare fresh, nutritious meals, but build community and a sense of self- efficacy as well.
- Another way to demonstrate respect for clients and build community is to provide special touches for holidays or birthdays, such as having volunteers make holiday cards and birthday cards. Birthday cakes made from scratch and delivered on birthdays can also be incredibly meaningful to clients who

may otherwise feel isolated or abandoned by friends and family at that time of year.

FOOD PANTRY SERVICES

- Unlike the food bank, where food must be provided in pre-packaged boxes according to a client's official meal plan, with a food pantry clients can choose items up to once per week, from staple foods (proteins, beans, bread, milk, eggs, coffee, and other non-perishable items/canned goods) and variety items (cheese, juices, etc.). When clients are accessing a food pantry, they may be allowed to swap items based on preference.

CONGREGATE MEALS

- In addition to providing food directly to individual clients, another option is to prepare food and offer it to clients in a congregate meal setting. In these cases, it is still critical that food is healthy, with a menu reviewed by a nutritionist or registered dietician. Food served must be balanced (i.e., must include proteins, fruits/vegetables, starches, vegetarian options / low-salt options) and interesting (e.g. include a reasonably healthy dessert!).
- Congregate meals should be served on set times and days to promote consistency and expand access by allowing information about the service to spread via word of mouth.
- Congregate meals should always be offered in safe spaces with priority placed on developing community and respecting all people attending the meal. This provides connection with peers and the surrounding community for clients, which is one of the main benefits of congregate meal provision.
- Meals must always be prepared with excellent kitchen sanitation and meet food preparation safety standards. Supplies for kitchen sanitation can be paid for under this service category if other options for funding or donation are not available.
- Congregate meals should cultivate a sense of warmth, respect, and community, and promote health and self-efficacy to eat nutritious food. This can be done through:
    - Offering seconds whenever possible, rather than restricting food intake.
    - Making the space feel like home. Some options include setting up tables with centerpieces, having volunteers bring service to the table and serve clients, etc. This promotes intimacy and respect for clients.
    - Taking every opportunity to refer clients to the Food Bank program and/or link them with a case manager or other service provider as appropriate. Often food service is an entry point to clients who are not already engaged in services.
    - Offering client engagement activities, including inviting speakers (i.e. about housing, employment, or other topics) to congregate mealtimes.
    - Asking for feedback: How was the food? What would you like us to serve next time, if we can? Then follow through to make improvements next time when possible.

Health Education/Risk Reduction – Support Service

INTRODUCTION:
This document describes the requirements and standards that apply to the "Health Education/Risk Reduction" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Health Education/Risk Reduction services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION:
Health Education/Risk Reduction entails the provision of information and services that are designed to reduce the risk of HIV transmission, promote treatment adherence, facilitate viral suppression, and encourage self-care. It includes:

- Providing information about available medical and psychosocial support services
- Coaching and counseling to help clients living with HIV improve their overall health and wellbeing

REQUIREMENTS:
All subrecipient agencies receiving funds under this service category are required to adhere to the following standards:

- **Client Identification:** Health Education/Risk Reduction services may not be delivered anonymously.
- **Content:** Topics for Health Education/Risk Reduction must include some or all of the following:
    - Education about reducing HIV transmission, such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for clients' partners, as well as 'Treatment as Prevention' (TasP), and 'Undetectable Equals Untransmissible' (U=U)
    - Coaching and support around disclosing HIV status, and linkage to Partner Services, including self-disclosure, dual-disclosure, and third-party notification options
    - Education about healthcare coverage options, e.g., Medi-Cal, Medicare, and/or qualified health plans such as Covered California
    - Health literacy, including an assessment of client knowledge and beliefs about various topics related to HIV health education and risk reduction
    - Education on available mental health and substance use treatment services and other resources
    - Treatment adherence education
    - Information about medical and psychosocial resources and other support available to people living with HIV.
- **Type of Sessions:** Health Education/Risk Reduction services can be offered on an individual basis or in group sessions, but must always be client-centered and non-judgmental.

- **Number of Sessions:** Group activities in this service category are limited to 8-12 sessions within a specified timeframe. They may also be offered as a single-session group when appropriate.

RECOMMENDED BEST PRACTICES:

- **Approach:** Health Education/Risk Reduction services are best offered in coordination with a medical case manager and/or other relevant service providers. Activities should include information about wellness (i.e., smoking cessation, diabetes management) and common co-infections such as STIs and Hepatitis C, as they relate to HIV health and risk reduction.
    - Whenever possible, Health Education/Risk Reduction activities should be based on principles of harm reduction, and should be centered around reducing HIV stigma and health disparities.
    - Clients should be linked with hepatitis C and STI screening and treatment, which improves the health of the client and reduces the potential for transmission to others.
- **Special Groups:** Health Education/Risk Reduction groups may be best organized around member similarities such as gender identity, sexual orientation, culture, language, recency of HIV diagnosis, location of residence, or age.

Home and Community-Based Health Services – Core Service

INTRODUCTION
This document describes the "Home and Community-Based Health Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Home and Community-Based Health Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION
Home and Community-Based Health Services are provided to an eligible client in an integrated setting appropriate to that client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services within the client's home
- Intravenous and aerosolized drug therapy (including prescription drugs given as part of such therapy)
- Routine diagnostic testing done in the home
- Personal care services that are necessary for activities of daily living (ADL), provided these services are not reimbursable by another payor the client is eligible for (e.g., IHSS, Medi-Cal, Medicare)

Program Guidance:
Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purpose of providing Home and Community-Based Health Services.

PURPOSE/GOALS
The purpose of Home and Community-Based Health Services is to assist clients and their significant others with developing and achieving their health goals. These services will address crises and stabilize clients' health status in order to promote health care maintenance and positive health outcomes. These services are intended to enable clients to safely remain in their homes, reduce hospitalizations, and improve the quality of health for people living with HIV while they are home bound.

REQUIREMENTS
All subrecipient agencies funded under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS
The following categories of providers may provide services in this service category. The type of provider must be determined by the client's needs.

- **Licensed clinical provider**: Must maintain a current and valid MD, DO, PA or NP state licensure.
- **Registered Nurse (RN):** Provides the highest level of Home and Community-Based care, including:
    - Skilled nursing care
    - Initial intake/assessment
    - Follow-up visit at least monthly
- A licensed vocational nurse (LVN) must work under the supervision of a licensed clinical provider or RN to provide skilled nursing care.
- Home care attendants or home health aides must have appropriate certifications, or other training, and receive supervision from an RN in addition to meeting the policies of their employer. This should include review of duties at least monthly.

Providers must be competent in addressing trauma and stigma and comfortable with the provision of services to the LGBTQ+ population and other populations affected by HIV. Providers must also be competent in providing non-judgmental care using harm reduction principles.

SERVICE CHARACTERISTICS
Home and Community-Based Health Services must include the following five components:

1. **Referral**: Initial referral to the agency is made by the client's case manager.
2. **Prescribing**: Home and Community-Based Health Services must be prescribed by a medical provider (MD, DO, PA, or NP)
3. **Screening/Intake**: Complete a comprehensive health assessment to identify both clinical and non-clinical client needs and address cultural and linguistic needs. The initial assessment must be completed by a licensed clinical provider (MD, DO, PA, NP) or registered nurse (RN).
4. **Goal Setting** The health provider will develop a treatment plan based on the comprehensive assessment.
    - Treatment plans should be created with input from the client.
    - Treatment plans should be reviewed every 1-2 months and updated as needed
5. **Evaluation/reassessment**
    - Prescription refresh
    - Done by an RN
    - Every 30-60 days

ALLOWABLE SERVICES: Funds may be used for the following Home and Community-Based Health Services:

- Attendant or home health assistance provided by a **home health aide (HHA)** or **other appropriately skilled attendant** who can assist with the ADL. Personal care services may only be provided to clients who need assistance with one or more Activities of Daily Living as determined by a medical provider or RN during the initial assessment.
    - Bathing and related personal care services, including skin, mouth and hair care

  - Assisting in and out of bed and with walking
  - Medication reminders for any medicines the client takes himself or herself; the home health aide or other unlicensed attendant may NOT administer medications of any kind
  - Meal preparation
  - Light housekeeping
  - Accompanying the client to medical appointments (attendant may not drive client to the appointment)
  - Routine allowable diagnostic testing administered in the home
  - Reporting changes in the individual's condition and needs to the supervising nurse or clinician
  - Completing records regarding services provided
- Skilled nursing services provided by an **RN** or **LVN**:
  - Initial intake and assessment (**RN only**)
  - Supervision of HHA or attendant (**RN only**)
  - Education
  - Pain management
  - Treatment adherence
  - Infection control
  - IV therapy
  - Dressing changes
  - Operation of durable medical equipment
  - Other activities taught by a health professional, such as changing colostomy bags, changing non-sterile dressings, taking vital signs, and non-sterile bowel and bladder hygiene care
- In general, Home and Community-Based Health Services does not include provision of 24-hour care. However, it may be included as part of the written plan of care if the treatment is clearly HIV-related and is declared necessary by the referring or attending provider.

ELIGIBILITY: Home and Community-Based Health Services may only be provided to clients using Ryan White funds when the service provider:

- Completes all of the agency's intake forms and processes per internal protocol
- Obtains permission to obtain the following labs from the primary care provider: lipids, metabolic panel, and CD4 count.
- Determines eligibility for services. To be eligible, the client must meet <u>at least one</u> of the following requirements:
  - Unable to reliably attend healthcare services in a standard facility
  - Unable to pay for medically indicated skilled care through other means

- Unable to perform their own housework or personal care as a result of illness related to their HIV
- Bed-bound
- Unlikely to be able to stand for more than 15 minutes at a time
- Unlikely to be able to walk more than 50 feet at a time
- Unlikely to be able to carry a weight of more than 15 lbs.
- Likely to need physical or other assistance in leaving home
- Requires 24 hours/day oxygen to treat lung or heart disease
- Requires someone to help client prepare/cook food
- Leaving home may create a safety risk or hardship

RECOMMENDED BEST PRACTICES

To provide services in this service category, home health aides should hold California Certified Home Health Aide Certification.

Linguistic Services – Support Service

INTRODUCTION
This document describes the requirements and standards that apply to the "Linguistic Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Linguistic Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION
Linguistic Services include both oral interpretation and written translation services that are provided to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client.

PURPOSE/GOALS
The purpose of Linguistic Services is to ensure clear communication between providers and clients and/or to support other aspects of Ryan White service delivery. Providers funded under the Linguistic Services service category should facilitate the provision of services regardless of the client's proficiency in spoken and/or written English or other barriers to communication.

REQUIREMENTS
All subrecipient agencies receiving funds to provide service under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS
The Linguistic Services provided must comply with the National Culturally and Linguistically Appropriate Services (CLAS) Standards, as established by the US Department of Health and Human Services.

- Qualifications/Certification: Staff providing linguistic services should have documentation on file demonstrating their language proficiency and any training or certifications received on interpretation skills and ethics. If possible, staff should have active certification through the National Board of Certification for Medical Interpreters or the Certification Commission for Healthcare Interpreters. American Sign Language interpreters should possess National Interpreter Certification or Certified Deaf Interpreter Certification, with additional documented proficiency in healthcare/medical vocabulary. If job candidates are bilingual/multilingual but do not possess certification, the subrecipient agency should facilitate the training and certification process as early as possible upon hire.
- Supervision: Subrecipient agencies are responsible for providing staff with supervision and training to develop competencies necessary for effective job performance. Additionally, staff must receive training during orientation and remain up to date on the following:
    - Training and continuing education topics outlined in the Universal Standards of Care
    - Navigation of the local system of HIV care

- Additional topics relevant to their position, including any training required to maintain licensure or certification.

- Examples of relevant HIV-specific topics and training modules can be found on the University of Washington's National HIV Curriculum website.

INITIAL INTAKE VISIT:

- **Screening/Eligibility:** At the initial intake visit with a new client, staff providing Linguistic Services must screen for insurance coverage or other payment sources in order to verify (either directly or via the referring provider) that RWHAP funds are being used as the payor of last resort. Eligibility screening and enrollment in coverage must comply with the eligibility procedures outlined in the Universal Standards of Care.
- **Intake**: Client records should include documentation of the client's primary and/or preferred language(s) for spoken and written communication. Other barriers or facilitators of communication and relevant details on the client's literacy level should also be documented.

KEY SERVICE COMPONENTS:

- Linguistic Services providers must provide translation/interpretation services for the date of any scheduled encounter or planned communication with an eligible client.
- Services may be provided in person or via telephone or other secure electronic means.
- Unless specifically requested by the client, a client's family member or friends must not be engaged as an alternative to a professional translator/interpreter.

CASE CLOSURE:
A case will be deemed closed when the client:

- Has transferred to an agency in a different service area;
- Has been assessed as no longer requiring Linguistic Services; or
- Is no longer eligible for Linguistic Services through the RWHAP.
    - If the client has a continuing need for services, efforts should be made to secure alternative coverage or facilitate linkage to a provider covered by their insurance.

Documentation in the client's record should include the date of discharge, reason or rationale for discharge, and any referrals or linkages made at the time of discharge.

PERFORMANCE MEASUREMENT:
To allow for performance monitoring, in addition to the client-level documentation outlined above, the Subrecipient agency providing Linguistic Services should maintain documentation of the following:

- For each client encounter:
    - Date of encounter
    - Name of interpreter/translator

  - Language involved
  - Type of service provided (written or oral)
  - Mode of interpretation (in-person, telephone, or videoconference)
  - Referring clinic or agency
- For each measurement period:
  - Number of unique clients served
  - Number of units of service provided
  - Languages in which services were provided
  - Names of referring agencies and number of clients referred by each agency

Medical Case Management – Core Service

INTRODUCTION
This document describes the "Medical Case Management" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Medical Case Management services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category.. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION
Medical Case Management consists of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Medical case managers may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible. It also includes Treatment Adherence Services to ensure a client achieves and maintains adherence to HIV treatments. **The role of an MCM is distinct from that of an NMCM as it is an integral part of the client's clinical care team, working in frequent contact with physicians, pharmacists, nutritionists, and other medical practitioners.**

- **Objective:** The objective of MCM services is to improve health care outcomes.
- **Goal:** The goal of MCM services is to move a client toward self-sufficiency.
- **Included Services:** MCM services may be delivered in the following ways:
    - Face-to-face in office
    - Face-to-face during a home visit
    - Secure videoconference via smartphone or computer
    - Phone contact
    - Secure text messaging
    - Any other secure forms of communication with clients

REQUIREMENTS
All service providers receiving funding under this RWHAP service category must adhere to the following standards:

PROVIDER QUALIFICATIONS AND OVERSIGHT:

- **Education and Experience:** To provide services in this category, providers must have the appropriate education and training, including:
    - Bachelor's, Master's, or Doctorate degree in Social Work or a related field,
    - Three years of experience in case management without a degree in social work or a related field is acceptable

Case managers may provide advanced medical case management under the following supervision requirements:

- Fully licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC) and Registered Nurses (RN) may practice independently within the scope of their practice and as authorized by their employers and respective licensing boards.
- Pre-licensure clinical case managers, including Associate Social Workers (ASW), Associate Professional Clinical Counselors (APCC), Associate Marriage and Family Therapists (AMFT), and students must receive clinical supervision according to the requirements of their licensing boards.
- Unlicensed non-clinical medical case managers must receive supervision according to the policies of their employer. This should include regular review of their caseload and case work by a licensed or associate clinical supervisor.

- **Scope of Practice:**
  - Medical case managers who are licensed clinicians or are working towards licensure may function according to the highest level of their professional scope, which may include:
    - Providing direct clinical care
    - Making clinical recommendations
    - Offering counseling, psychotherapy, and emotional support
    - Providing advanced health education
    - Perform comprehensive assessment and provide diagnostic impressions consistent with licensure and scope of practice
    - Ensuring the provision of quality care across the healthcare spectrum
    - Reviewing charts and overall care to ensure appropriate clinical care and the optimal utilization of services
- **Quality Management**
  - All subrecipients funded for Medical Case Management services must have a written quality management on file for review. The plan will be used to conduct clinical chart reviews by supervising staff to evaluate and assess the client's documented care for alignment with key indicators.

KEY ACTIVITIES

Key activities of Medical Case Management include:

- **Initial Assessment:** Determining the client's needs and program eligibility. Each initial assessment should include a complete needs assessment (see below)
- **Care Plan:** Development of a comprehensive, individualized care plan for each client, developed with the client's input and signed by the client. Case managers are expected to teach clients about case management, develop and reassess care plans, and collect and document the results of the care plan

- **Coordinating Care:** Working with providers to ensure that the client receives prompt referrals to all types of care the client needs and that are medically appropriate. This includes tracking and following up of all referrals
- **Monitoring:** Continuous client monitoring to determine whether the care plan is working. For MCM, monitoring involves assessing clinical indicators, such as a client's medication adherence, follow-up on missed physician visits, and any changes in medical condition.
- **Evaluation and Adjustment:** As needed, and at least every 6 months, reviewing the status of the client's engagement in medical care, and adjusting the care plan to reflect progress, barriers, and new goals
- **Needs Assessment:** Ongoing assessment of the client's and other key family members' needs and personal support systems. The MCM assessment is clinically-oriented, focusing on medical needs, medication regimens, and interactions within the clinical care team. Assessment should include the following needs and characteristics:
    - Benefits counseling and insurance coverage
    - Medical care including HIV care, primary care, and medical referrals
    - Adherence to medication, appointments, and labs
    - Mental health, including the need for psychiatry and psychotherapy
    - Substance use history and need for substance use treatment and addiction support
    - Health education, health promotion, and disease prevention
    - Usage of core and support Ryan White services
    - Sexual health behaviors
    - Family make-up
    - Evaluation and improvement of social and community support systems
    - Housing navigation assistance
    - Transportation coordination
    - Risk reduction counseling
    - Partner notification and disclosure
    - Environmental and interpersonal safety
    - Legal support
    - Access to food resources and nutritional assessment
    - Dental care
    - Language and cultural needs
    - Financial assistance, including emergency financial aid needs
    - Spiritual care
- **Medication Intake Counseling:** Ensuring a client achieves and maintains adherence to HIV treatments through the use of motivational interviewing and other evidence-based strategies.
- **Orientation**: New clients should be given a complete orientation to the agency, including written information about agency services, grievance/mediation services, privacy practices, and other resources in the client's preferred language
- **Advance Planning:** Advance directives, durable powers of attorney, living wills and other planning documents, including "Do Not Resuscitate" (DNR) orders and status, and permanency planning for dependent children should be addressed at the beginning of treatment and at any appropriate time throughout the course of follow-up visits.

CLIENT ACUITY LEVELS AND CLASSIFICATION

- **Active clients** are clients who have had successful contact with Medical Case Management services within the last 6 months. Agency caseloads should be largely comprised of active clients.
- **Acuity (Need) Levels:** Case management services should be provided based on the client's level of need. Clients should be:
    - Assessed at intake using an acuity scale, such as the one of the examples included in the Appendix of this document.
    - Knowledge of a client's level of need should assist agency staff in determining the caseload for a particular medical case manager.
- **Classifications:** Acuity levels shall be categorized in the following ways and determine both the frequency and intensity of engagement:
- **Level 1 (single encounter).** Level 1 clients are high-functioning clients that have only one or two needs and do not require or justify a full initial assessment or needs assessment. Their needs can typically be addressed in one appointment with the case manager with minimal support (for example, assistance with applying for Medi-Cal and no other needs). Clients may remain enrolled in Medical Case Management as long as they have needs that require the assistance of a case manager, as documented in the care plan. Clients must be eligible for Ryan White and all eligibility documentation must be completed regardless of acuity.
- **Level 2 (functioning well).** Level 2 clients typically have several needs that are more complex than those of clients in Level 1. They are typically able to maintain health, employment, and activities of daily living (ADLs) with limited help. Clients at this level may benefit from:
    - Screening, intake, and identification of needs through a comprehensive assessment
    - A health history
    - Help coping with a new HIV diagnosis
    - Treatment adherence counseling, including understanding medications and health consequences related to poor adherence
    - Risk/harm reduction counseling and outpatient substance use treatment
    - Referrals to specialists and other services
    - Help applying for health insurance and other critical benefits
    - Assistance with disclosing HIV status to partners (Partner Services)
    - Care coordination across multiple providers and systems (e.g., pharmacy, specialty care, etc.)
- **Level 3 (urgent needs or extensive problems).** Level 3 clients require repeated and more frequent contacts than those at Level 2 and Level 1. They may have multiple problems as well as difficulty following through with their care plan by themselves. One or more of their needs may be urgent. Clients at this level benefit from:
    - All interventions appropriate for Level 1 and Level 2 clients

- Frequent contacts from their case manager to ensure progress on care plan goals
- Significant help with medication and appointment adherence
- Mitigating health complications from poor adherence
- Managing advanced disease states
- Financial counseling and other interventions to address financial insecurity including unemployment
- Assistance with complex legal issues
- Assistance addressing immediate violence or other safety issues
- Assistance addressing risk of homelessness or eviction or other urgent housing needs
- Follow-up from a recent emergency room visit and/or inpatient stay

- **Level 4 (severely impacted).** Level 4 clients require immediate assistance and very close and frequent follow-up. They benefit from:
  - All interventions from Level 1, Level 2, and Level 3, as well as:
    - Crisis intervention and general stabilization
    - Housing coordination to address homelessness or other pressing housing issues
    - Assistance with immediate and/or chronic food insecurity including episodes of hunger
    - Addressing a significant loss of income or lack of income
    - Help with a disabling condition or other loss of ability to complete ADLs
    - An immediate need for a higher level of care such as intensive case management, inpatient or residential substance use treatment, intensive counseling including psychiatric treatment, urgent or emergent health care services, or home health care
    - Follow-up from a high utilization of health care services.

INITIAL ASSESSMENT OF SERVICE NEEDS

- **Barriers**: Barriers to accessing medical care must be documented in the initial assessment. Medical Case Management services must be offered in a way that addresses these barriers and uses resources to support positive health outcomes for clients.
- **Eligibility/Assessment:** At the initial intake visit of a new Medical Case Management client, agency staff must screen for eligibility and conduct a full intake assessment, **including verification of baseline genotype testing completion,** unless the client is the lowest acuity and is assigned to Level 1.
- **Referral:** Clients ineligible for RWHAP MCM services must be referred to another community-based organization or linked to another appropriate community-based organization or safety net provider. All referrals must be documented and made available upon request.
- **Primary Case Manager:** Each client should have one case manager designated as the primary case manager. That staff person will act as the coordinator with other members of the treatment team.

DEVELOPMENT OF A COMPREHENSIVE, INDIVIDUALIZED CARE PLAN

- **Frequency:** An individualized care plan must be developed at intake and reassessed every 6 months.
- **Requirements:** Case managers developing an individualized care plan will, at a minimum:
    - Set realistic goals, objectives, and timelines based on needs identified by client, case manager, or both
    - Identify resources to attain the goals and objectives, including collaboration with other relevant providers (e.g. substance abuse counselors, physicians, housing specialists, etc.).
- **Updates:** As the client's status changes, the client and case manager will work together to establish new goals, objectives, and timelines.
- **Documentation:** Completed individualized care plans must be kept in the client file, signed by both client and case manager.

- **Client Record:** All records kept should adhere to the requirements of the Universal Standards of Care.
- **Case Conferencing:** Case conferences should be held for clients to coordinate care among providers from different fields (disciplines). A release of information (ROI) should be obtained from the client before disclosing personal health information (PHI) with outside agencies.
    - **Discussion:** During case conferencing, a review of the care plan and an evaluation of the services the client is receiving should be performed, as well as the client's current status (coordinating care, troubleshooting problems with maintaining the client in care, strategies to re-engage client in care, etc.).
    - **Client Input:** The client and/or his/her caregiver or legal representative may provide input to the case manager during case conference and telephone contacts. Case conferences may also be conducted without the client present. In this case, the outcome of the case conference should be discussed with the client.
    - **Documentation:** Appropriate documentation must be kept in the client's chart, including names and titles of those attending the case conference, key information discussed, and whether the client or legal representative had input into the conference and the service outcome.

PERIODIC REASSESSMENT, RE-EVALUATION, and REVISION OF THE CARE PLAN

- **Assessment:** Case Managers should routinely review the success in achieving service outcomes as outlined in the service plan, measure progress in meeting goals and objectives, and revise the plan as necessary.
    - **For Level 1** clients, progress against goals should be tracked by the case manager. Reassessments are not necessary unless additional needs arise. In this case, the client should be re-evaluated for a higher level of acuity.
    - **For Level 2** clients, face-to-face assessments should be conducted every 6 months. Clients must have contact with their medical case managers for RWHAP re-certification every 12 months,
    - **For Level 3** clients, contact must be made every 60 days

- **For Level 4** clients, the frequency of contact with the client should be every 60 days or sooner, based on the acuity of the client's needs.

- **Documentation:** Case Managers must routinely document the outcome of reassessments and service activities in the client record.

Core Performance Measures:

Linkage to Care	Was the client linked or relinked to care in 30 days or less?
Rapid ART	Was the client prescribed ART at their first medical visit?
Medical Visit	Did the client have at least one medical visit during the measurement year?
Retention in Care	Did the client have 2 medical visits at least 90 days apart in the last 12 months?
Viral Suppression	Did the client reach an HIV viral load of <200 copies/mL at their latest test?

CLIENT TRANSFER OR GRADUATION

- **Transfer of Clients:** Transfer of clients between agencies or case managers is initiated when:
  - The client notifies the case manager that the client has moved to a different service area or outside of the TGA
  - The client notifies the case manager of their intent to transfer services
  - The client has followed the grievance procedure, or
  - The agency no longer receives funding.
- **Client Graduation:** Clients may graduate from case management when they have reached their goals or their priorities have changed and they no longer wish to receive case management services. Clients may also graduate from one acuity level to another as their documented needs change. Client graduation or change of acuity should be documented in the client's records
- **File Closure:** Agencies should close a client's file according to the written procedures established by the agency, for reasons including but not limited to (a) death, (b) relocation, (c) transition to another provider, (d) request of the client, or (e) there is no client contact for longer than 6 months.
  - **Record Maintenance:** Medical Case Management files must be held in a secure place for a minimum of 5 years after a case is closed, or 7 years when the case includes hospital records.

Medical Nutrition Therapy Services – Core Service

INTRODUCTION
This document describes the "Medical Nutrition Therapy Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Medical Nutrition Therapy Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Requirements
- Preferred Provider Qualifications

SERVICE DEFINITION
Medical Nutrition Therapy Services (MNTS) are provided by a credentialed registered dietitian outside of a client's primary care visits and may include the provision of nutritional supplements. MNTS provided by someone other than a registered dietitian should be recorded under psychosocial support services.

PURPOSE/GOALS
The purpose of MNTS is to enable clients to improve health outcomes by providing dietary interventions and education to clients that is consistent with their health status and nutritional needs.

REQUIREMENTS
All service providers receiving funds under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS
To provide services in this service category, providers must maintain a current and valid Registered Dietitian (RD) credential.

SERVICE CHARACTERISTICS

- **Obtaining Services:** MNTS are offered by referral from a licensed clinical provider or medical case manager.
- **Care Plan:** Requires a coordinated care plan
    - RD must work in concert with other providers
    - Regular reassessment to revisit and revise the nutritional care plan is required
        - May result in the creation of a new care plan, continuation of existing plan, or disenrollment/success
- **Health History Assessment:** Provider must conduct a health history assessment, which includes,
    - Baseline body weight, measured for normal weight and height without shoes, and vital signs
    - Medical history, including current medications, immunity, overall well-being, and any complications or other medical problems (i.e., diabetes, cardiovascular, kidney and liver diseases)

- Assessment of client's nutritional status, including such factors as
  - Weight changes
  - Current medications
  - Side effects
  - Symptoms
  - Client functioning
  - Change in body appearance
  - Lab work, where available
- Nutritional counseling on basic dietary needs and menu planning
- Nutrition education based on the client's nutritional assessment. This may include:
  - Education about nutritional needs ensuring adequate diet with balanced intake of macro-nutrients
  - Safe food handling and preparation
  - Identifying/addressing misinformation
  - Addressing nonspecific symptoms and fatigue
  - Preventing weight loss and potential wasting
  - Exploring the use of alternative therapies, herbals, etc.
  - Provision of adequate calories to diminish the effects of malnutrition

- Providers should, when possible, obtain detailed lab work, including specific nutrient deficiencies, HgA1C, and others, as appropriate

- **Recommendations and Referrals:** RD may make additional recommendations or referrals as appropriate
  - Referral to food-assistance programs, emergency food providers, and food stamps, with follow-up as appropriate
  - Written authorizations for nutritional supplements
- Recommendation for a medication evaluation to the medical provider to address nutrition-specific issues (i.e., loss of muscle and loss of appetite)

PREFERRED PROVIDER QUALIFICATIONS

Providers must have some level of knowledge/population skills related to people living with HIV or be willing to obtain these skills via continuing education.

Medical Transportation Services – Support Service

INTRODUCTION:
This document describes the requirements and standards that apply to the "Medical Transportation Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Medical Transportation services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the service definition and program requirements.

SERVICE DEFINITION:
Medical Transportation Services include transportation services provided to a client through transportation vouchers or via on-demand or scheduled transportation. Medical Transportation Services are intended to remove the transportation barriers that prevent clients from accessing necessary HIV-related health and support services, and to enable them to access goods or services to improve their health status.

REQUIREMENTS:
All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to adhere to the following standards:

- **Use of Services:** Medical Transportation Services are prioritized to help clients attend medical appointments and other core medical services. However, they may also be used for support services if funding is available.

- **Requirements:** When Medical Transportation Services are provided in the form of rides that are offered directly by the subrecipient agency, the agency must ensure that:

    - Vehicles, drivers, and scheduling are reliable

    - Drivers must possess a valid driver's license in the correct class and a safe driving record

    - Vehicles are appropriately registered and comply with current safety laws

    - ADA-compliant transportation options are available for use by clients with disabilities

    - Case managers and other providers are kept informed of any changes to transportation availability.

- **Requirements:** Subrecipient agencies that offer Medical Transportation Services in the form of vouchers for Paratransit, taxi, AC Transit/County Connection, and/or BART, etc. must ensure that:

    - A system is in place to account for disbursed vouchers

    - Written procedures have been developed regarding the documentation needed when issuing, storing and transporting vouchers and

    - Staff are trained on agency procedures.

- Staff document date and type of transportation voucher distributed.

- **Exclusions:** Medical Transportation Services cannot include:
  - Payments for parking or tolls
  - Cash payments to clients

- **Personnel and Vehicles:** Transportation providers, i.e., van transportation services, must document the following in their employee/volunteer records or in agency policies, as appropriate:
  - A copy of each driver's current driver's license
  - A copy of each driver's DMV driving record, which must be checked annually by the service provider
  - Eligible drivers may not have more than two DMV points over the past three years
  - Evidence of current automobile insurance coverage
  - Service records showing the vehicle is well-serviced and has passed any required safety inspections for vehicles that carry commercial passengers
  - Evidence that all drivers have successfully completed a defensive driver's course
  - Evidence that all drivers have completed CPR and/or first aid courses.

Mental Health Services – Core Service

INTRODUCTION

This document describes the "Mental Health Services" category of core medical services under RWHAP. Subrecipient agencies that receive RWHAP funds to provide Mental Health Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Requirements
- Recommended Best Practices

SERVICE DEFINITION

Mental Health Services are outpatient psychological and psychiatric screening, assessment, diagnosis and treatment services for individuals, which may extend to their significant others when deemed clinically appropriate. Services may be offered in a group or individual setting and must be provided by a mental health professional who is licensed or authorized by California to provide those services. This typically includes psychiatrists, psychiatric nurse practitioners, psychologists, marriage and family therapists, licensed professional clinical counselors, and licensed clinical social workers – including those working toward licensure.

PURPOSE/GOALS

The goal of Mental Health Services is to assist clients and their significant others in developing and working toward achieving their mental health and wellbeing goals. These services are intended to help clients better address crises and aid in stabilizing clients' overall mental health status to promote health care maintenance and positive health outcomes.

REQUIREMENTS

All agencies receiving funds to provide service under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS

To provide services in this service category, providers must:

- Maintain a current and valid **licensure** where appropriate:
    - **Psychiatrist:** M.D. State licensure
    - **Psychologist:** State licensure
    - **Psychiatric Nurse Practitioner:** State licensure
    - **Clinician:** M.F.T., L.C.S.W., PhD or PsyD, LPCC
    - **Registered or student interns on the path to licensure:** May provide services with licensed supervision
- Licensed clinicians may practice independently within the scope of their practice and as authorized by their employers and respective licensing boards
    - **Competencies:** Providers must be trained to address trauma, stigma and substance use experienced by the LGBTQ+ population and other populations affected by HIV. Providers

must be competent in providing non-judgmental care using motivational interviewing and harm reduction principles.

- **Scope of Practice:**
    - Clinicians may function according to the highest level of their professional scope, which may include:
        - Providing direct clinical care
        - Making assessment and clinical recommendations
        - Offering counseling, psychotherapy, and emotional support
        - Diagnosing clients within the scope of their practice
        - Supporting clients to maintain engagement in medical care and adherence to medications and treatment plans
        - Reviewing charts and overall care to ensure appropriate clinical care and the optimal utilization of services
        - Referring to medication management services

SERVICE CHARACTERISTICS

Mental Health Services must include the following four components:

- **Screening/Intake**:
    - Complete a comprehensive mental health assessment using a current mental health assessment tool, which identifies both clinical and non-clinical client needs and addresses cultural and linguistic needs.
- **Treatment Plan Development** The mental health provider will develop a treatment plan based on the comprehensive assessment.
    - Treatment plans should be created with input from the client(s) and are required for individual, couple, family, and group therapy
    - Treatment plans should be reviewed every 6 months
    - Treatment plans must include, at minimum:
        - Diagnosed mental illness or conditions
        - Treatment modalities that will be used
        - Goals and objectives for therapy
        - Date the plan was developed and dates of any updates
        - Recommended number of sessions
        - Projected treatment end date
        - Signature of the mental health professional rendering service

- **Support, Referral, and Coordination of Services:** Services are part of the coordinated continuum of care. Staff provide immediate support and referrals for urgent, crisis, and emergency situations, including violent or suicidal behavior.
    - Mental health staff should provide appropriate referrals when clients have acute mental health needs that fall outside of the scope of the funded services or competency of the clinician.
    - Clients should be referred to support groups when appropriate.
    - Clients not currently accessing medical care should be referred to a primary care provider.
    - Other providers should be aware that the client is accessing Mental Health Services as appropriate. Releases of information must be obtained as required by law when communicating with outside providers.
- **Case Closure:** A case should be closed when:
    - All treatment goals have been achieved
    - There has been a request for closure by the client
    - There has been no direct contact with the client in 6 months or more, despite multiple attempts made by the provider. At this stage the client is deemed lost to follow-up
    - The client is no longer eligible or has moved out of the service area
- **Case Closure Summary:** The clinician must document a case closure summary for each client who has terminated treatment, including:
    - Course of treatment
    - Discharge diagnosis
    - Referrals
    - Reason for termination
    - Documentation of attempts to contact the client, including written correspondence and results of these attempts (for those clients who drop out of treatment without notice)
- Prior to closing the case (with the exception of death), the mental health provider should:
    - Make it clear to the client what case closure means
    - Inform the client of the process and requirements for reentry

Non-Medical Case Management – Support Service

INTRODUCTION

This document describes the "Non-Medical Case Management Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Non-Medical Case Management (NMCM) services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Requirements

SERVICE DEFINITION

NMCM is the provision of a range of client-centered activities focused on improving access to and retention in essential core medical and support services by mitigating or eliminating the social, logistical, and financial barriers that impede engagement in care. The NMCM is not part of the clinical team but rather serves as a navigator of community and social services. NMCM provides coordination, guidance, and assistance in accessing medical, social, community, legal, financial, employment, vocational, and/or other needed services. NMCM Services also includes assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Children's Health Insurance Program, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, Department of Labor or Education-funded services, other state or local health care and supportive services, or private health care coverage plans. NMCM Services includes all types of case management encounters (e.g., face-to-face, telehealth, phone contact, and any other forms of communication).

PURPOSE/GOALS

To assist clients with developing and achieving their NMCM goals. These services will address client needs to remain retained in care.

> **Program Guidance:** NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

REQUIREMENTS

All service providers receiving funding under this RWHAP service category must adhere to the following standards:

- **Education and Experience:** While completion of a formal degree or certificate program is not required, staff providing Non-Medical Case Management services should possess at least two years of relevant work experience. Additionally, staff must have the knowledge and skills required to perform effectively in the position, including:
    - Knowledge about the social barriers to care commonly faced by people living with HIV
    - Knowledge of the local service delivery system

- Ability to establish rapport with clients from diverse backgrounds
- Written and verbal communication skills to successfully navigate complex institutions and processes

If agencies funded under this service category wish to consider candidates missing one or more of the above qualifications, they must develop a process and curriculum for training new staff in each of the required topics or skills (in addition to their standard new staff orientation topics).

Scope of Practice:
Non-medical case managers support clients to address barriers to care that are not clinical in nature. Under this service category, staff may not provide services focused on addressing medical barriers, including, but not limited to, providing treatment adherence counseling.

KEY ACTIVITIES
Key activities of Non-Medical Case Management include:

- **Needs Assessment:** An initial assessment of a client's needs across a broad spectrum of non-medical areas, including food security, housing, transportation, legal assistance, and employment. Clients should be assessed at intake using an acuity scale to determine their level of need for case management. This practice supports the federal guidance that NMCM, in particular, is a service based on need and is not necessary for every client. Assessments should include the following needs and characteristics:
  - Benefits counseling and insurance coverage
  - Usage of core and support Ryan White services
  - Family make-up
  - Evaluation and improvement of social and community support systems
  - Housing navigation assistance
  - Transportation coordination
  - Legal support
  - Language and cultural needs
  - Financial assistance, including emergency financial aid needs
  - Spiritual care

  Note: If the agency doesn't have an acuity tool specific to NMCM, they are encouraged to adapt one of the tools described in the Medical Case Management Standards of Care to focus only on non-medical factors.
- **Individualized Care Plan Development:** The development of a comprehensive, individualized care plan focused on addressing identified barriers to care.
  - At minimum, the care plan should:
    - Include goals and timelines based on needs identified by the client, case manager, or both
    - Identify resources to attain the goals and objectives, including collaboration with other relevant service providers
  - NMCM staff should conduct continuous client monitoring to assess the efficacy of the care plan to track progress toward the resolution of social barriers, such as whether a client has successfully secured housing, enrolled in public benefits, or obtained transportation assistance.

    - The care plan should be reassessed at least every 6 months, with updates noted as necessary. If there are significant changes to the client's barriers and/or supports, the client and case manager will work together to establish new goals and timelines
- **Coordination and Assistance:** The provision of guidance and assistance in accessing a wide range of social, community, legal, financial, and other needed services.
- **Benefits Counseling:** A key function is assisting eligible clients in obtaining access to other public and private programs, such as Medi-Cal, Medicare Part D, and state pharmacy assistance programs, for which they may be eligible.
- **Client Advocacy:** Providing client-specific advocacy to address and remove barriers to services.

Oral Health Services – Core Services

INTRODUCTION
This document describes the requirements and standards that apply to the "Oral Health Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Oral Health Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION
Oral Health Services includes outpatient diagnostic, preventive, and therapeutic services by a dental health care professional, including general dental practitioners, dental specialists, dental hygienists, and registered dental assistants.

PURPOSE/GOALS
The purpose of Oral Health Services is to provide access to routine and emergency dental care for eligible persons living with HIV. Periodic preventive and educational services reduce the incidence of more serious dental and periodontal conditions, maintain and improve the oral health of clients, and increase their ability to sustain proper nutrition.

REQUIREMENTS
All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS:

- **Licensing and Certification:** Dentists and dental hygienists must maintain valid DDS or dental hygienist state licensure. Dental assistants should possess a certificate from a qualified training program.
- **Supervision:** Auxiliary staff members must be supervised by a qualified dentist or dental hygienist. Additionally, providers and staff members must receive training during orientation and remain up to date on the following:
    - Training and continuing education topics outlined in the RWHAP Universal Standards of Care
    - Navigation of the local system of HIV care, including how to assist eligible clients with enrollment in the Employer Based Health Insurance Premium Payment (EB-HIPP) or the Office of AIDS Health Insurance Premium Payment (OA-HIPP) programs to cover premiums for dental insurance
    - Additional topics relevant to their position, including any training required to maintain licensure.

  Many clinical HIV topics, including oral health for people living with HIV, are covered in the University of Washington's National HIV Curriculum course modules.

INITIAL INTAKE VISIT:

- **Screening/Eligibility:** At the initial intake visit for a new client in this service category, staff must screen for Medi-Cal or other available payment sources and verify eligibility either directly or via the referring provider. This process ensures the client can access the most comprehensive payment source available and also preserves RWHAP funds as the payor of last resort. All eligibility screening and enrollment in coverage must follow the procedures outlined in the Universal Standards of Care.
- **Health History Assessment:** Once eligibility has been established, providers are required to conduct a health history assessment which includes:
    - Prior dental and medical history
    - Contact information for primary care providers
    - Current medications and changes in regimen
    - Known allergies
    - Current and past alcohol, tobacco, and other substance use
    - Laboratory data, including:
        - CD4 and HIV viral load
        - Hepatitis A, B, and C screening
        - Dental X-rays
        - Review of any HIV-related oral conditions and treatment modes

ANNUAL DIAGNOSTIC SERVICES: Services to be provided at each annual exam include:

- An oral exam, including dental caries examination, soft tissue examination
- A periodontal exam, including examination of pocket depths, gingival inflammation, plaque index, fremitus, gingival recession, bleeding assessment and tooth mobility
- A head and neck exam, including documentation of facial symmetry, lymph nodes, thyroid glands, and/or lips
- Evaluation for temporomandibular disorders, when appropriate
- Any services to diagnose or treat current conditions or to prevent future conditions, as specified in the treatment plan. These may include:
    - Cleanings, one or more times per year, as deemed necessary
    - Anesthesia services, as needed
    - Bridges
    - Root canals (non-front teeth)
    - Prostheses, dentures, and denture aftercare

ROUTINE DENTAL HEALTH MAINTENANCE: Services to be implemented during routine dental health maintenance visits include:

- Routine examinations and prophylaxis twice each year
- Comprehensive cleaning at least annually
- Other procedures, such as root planning/scaling as needed

TREATMENT PLAN DEVELOPMENT AND IMPLEMENTATION: A written treatment plan should be developed, with input from the client, and updated at least once each year. The following elements should be included in the treatment plan:

- Patient's primary reason for the initial dental visit and other client-requested services
- Client's level of need, including the determination of emergency vs. non-emergency care, triage care, and referral as indicated
    - Priority should be given to pain management, infection, traumatic injury or other emergency conditions
- Consideration of other factors, including:
    - Tooth and/or tissue-supported prosthetic options
    - Fixed prostheses, removeable prostheses, or combination
    - Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics and parafunctional habits
    - Restorative implications, endodontic status, tooth position and periodontal prognosis
    - Craniofacial, musculoskeletal relationships
    - Education on disease prevention
    - Appropriate evidence-based treatment(s) that will be provided
- Identification of resources for after-hours emergencies

ORAL HEALTH EDUCATION: Oral health education should be provided to the client at least annually, and should include the following components focusing on both disease prevention and the maintenance of oral health:

- Instruction on oral hygiene (proper brushing, flossing and mouth rinses)
- Instruction on soft tissue care
- Counseling on behaviors that may impact oral health, including tobacco use, unprotected oral sex, and body piercings
- Counseling on pain management, if applicable
- The effect of nutrition on oral health

SUPPORT, REFERRALS, AND COORDINATION:
As appropriate, the provider should identify and communicate with the client's other providers to support coordination and delivery of high-quality care, including:

- Coordination with the client's primary care provider as needed, including sharing of relevant medical

and dental records, particularly if the client receives HIV medical care from an outside agency

- Providing appropriate referrals to any specialty care necessary for the client's treatment plan
- Tracking referrals both into the agency and out to other services and providers, when related to the oral health treatment plan.

PERFORMANCE MEASUREMENT: To allow for performance monitoring on key HIV oral health measures, the dental care team should ensure that each client's dental record includes documentation of the following:

- Annual dental and medical health history
- Up-to-date dental treatment plan
- Annual periodontal screen or examination completed
- Annual oral health education provided to the client
- Completion of Phase I treatment plan within 12 months. Phase I treatment includes:
    - Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This may include:
        - Restorative treatment
        - Basic non-surgical periodontal therapy
        - Basic oral surgery that includes simple extractions and biopsy
        - Non-surgical endodontic therapy
        - Space maintenance and tooth eruption guidance for transitional dentition.

If possible, the above documentation should be captured in structured data in the dental record to allow for complete and accurate reporting.

Other Professional Services - Legal Services – Support Service

INTRODUCTION
This document describes the requirements and standards that apply to the "Other Professional Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Other Professional Services – Legal Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Requirements
- Recommended Best Practices

SERVICE DEFINITION
Other Professional Services consist of professional and consultant services, including legal services, the goal of which is to stabilize the client's life circumstances, engage and retain the client in treatment and care, enable access to medical care, and improve the client's quality of life and health. All people living with HIV who meet Ryan White eligibility requirements are eligible to receive RWHAP-funded legal services, subject to payor of last resort requirements.

Services provided in this service category must address legal issues that are directly related to the client's HIV status. All services should be client-centered, nonjudgmental, trauma-informed, and culturally appropriate.

These services may include, but are not limited to:

- Legal interventions that are necessary to ensure access to, and continuing receipt of, eligible financial and healthcare benefits
- Representation of clients in complaints related to discrimination or breach of confidentiality legislation as they relate to RWHAP-funded services.
- Healthcare powers of attorney, durable powers of attorney, advance healthcare directives, living wills, and do-not-resuscitate (DNR) orders
- For people living with HIV who are no longer able to care for their legal dependents, permanency planning that includes adoption, custody, or guardianship options
- Preparation of federal income tax returns, to assist in filing tax returns that are required by the Affordable Care Act for individuals receiving premium tax credits
- Expungement of criminal records, including payment of associated costs, for people living with HIV who have had legal system involvement, to the extent that it will assist in reducing barriers to care, mitigating stigma, and obtaining access to services and benefits that will improve HIV-related health outcomes (The addition of this eligible service was announced in a HRSA letter to Ryan White HIV/AIDS Program Colleagues on June 6, 2024).

When a client requests services that are not allowable under RWHAP, the provider must refer them to other professional services, such as private attorneys, bar referral panels, or other appropriate legal and/or professional resources.

RWHAP funding cannot be used to represent a client in any of the following cases:

- Torts, i.e. lawsuits brought by claimants against persons who have caused them to suffer loss or harm

- Criminal cases, when the issue is not related to HIV
- Class action lawsuits, unless the lawsuit pertains to access to RWHAP-funded treatment and care
- Fee-generating cases
- Complex litigation
- Civil cases that are unrelated to the client's HIV status, such as divorces, disputed wills, etc.

REQUIREMENTS
All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS:
Other Professional/Legal Services must be provided by members of specific professions who are licensed by state authorities to offer such services. Attorneys and staff that provide HIV legal assistance must have the skills and ability to specialize in the areas of most critical need to people living with HIV.

- Staff attorneys must be licensed by the State of California and members in good standing with the State Bar of California. Staff attorneys are responsible for providing, coordinating, and/or supervising all services.
- Licensed volunteer attorneys, law school graduates, law students and other legal professionals may be used to expand program capacity and must work under the supervision of a qualified staff attorney.
- All legal assistance staff and volunteers on site must complete an agency-based orientation before providing services.

PROVIDER RESPONSIBILITIES:
Legal representatives will provide advice, representation, and advocacy necessary to accomplish the client's goals, and must also:

- Represent, advocate and negotiate on the client's behalf using letters, phone calls, agency visits and court visits
- Document all contacts made on the client's behalf, either electronically or by hand-written notes in the client's file
- Ensure that all written communication on the client's behalf is kept in the client's file, whether the communication is by letter, fax, email or other means
- Ensure that all client files are kept in locked storage at all times, and not in the direct possession of the legal representative
- Inform the client that they will be given the opportunity to take their personal papers and health records with them at the time the case is completed
- Inform the client at intake that it is his/her/their responsibility to keep the legal staff informed of any changes relevant to their legal issue(s), including contact information, housing status, health conditions, hospitalizations, and involvement as an adverse party in a lawsuit.

MONITORING OF CASES:
The supervising attorney will:

- Document acceptance of new cases
- Monitor the progress of client cases
- Approve the planned course of action after discussion with the client's non-professional representative and

- Monitor the work of all non-professional staff members who are working with the assistance of other staff attorneys.

OTHER STANDARDS:

- Agencies must have written standards and plans for providing services.
- Caseloads must be of reasonable size and cases must be accepted on a priority basis.
- If a waiting list exists, the agency must have a written procedure for regularly communicating with clients about their wait-list status.
- The agency must have written criteria for its services, including fee structure, intake process, and discharge, transfer and closing procedures.
- Clients must receive written information about the above policies before receiving services, and the client's record must include documentation that this information was provided.

RECOMMENDED BEST PRACTICES

The following services may be provided to clients with the legal issues are directly related to the client's HIV status:

- Representing RWHAP clients in appeals and administrative law hearings related to denial or termination of benefits under SSI/SSDI, Unemployment Insurance, In-Home Supportive Services (IHSS), Cash Assistance Program for Immigrants (CAPI), CalWORKs, General Assistance, and CalFresh
- Assistance in obtaining reasonable accommodation of a disability
- Preparation of court documents related to name and gender changes
- Eviction prevention and defense, when loss of housing would create a barrier to retention in treatment and care
- Legal advocacy related to claims of asylum due to HIV status or sexual orientation
- Legal services related to family violence, when family violence would create barriers to retention in treatment and care.

Outpatient/Ambulatory Health Services – Core Service

INTRODUCTION

This document describes the requirements and standards that apply to the "Outpatient/Ambulatory Health Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Outpatient/Ambulatory Health Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION

Outpatient/Ambulatory Health Services should be offered alongside Medical Case Management services and provided by **professional diagnostic and therapeutic services given by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional in an outpatient setting.** Settings may include clinics, medical offices, and mobile vans where clients generally do not stay overnight, urgent care settings, and telehealth. **Emergency room services are not considered outpatient settings. Emergency room visits are not allowable costs within the OAHS service category.** Outpatient/Ambulatory Health Services are HIV-focused, and primarily include:

- Diagnostic testing, including laboratory testing
- Behavioral risk assessment, with counseling and referral as indicated
- Preventive care and screening for opportunistic infections (OI), tuberculosis (TB), sexually transmitted diseases (STDs), and hepatitis C
- Physical examination
- Medical history taking
- Prescription and management of medication therapy
- Pediatric developmental assessment
- Education and counseling on health and prevention issues
- Referral to, and provision of, specialty care related to HIV diagnosis, including all medical subspecialties

Services can be provided through this service category either as:

- Ongoing and consistent HIV care, or
- A one-time assessment with a specific procedure and follow-up for that procedure as needed, depending on the needs of the client.

As with all RWHAP services, Outpatient/Ambulatory Health Services are only to be used as the payor of last resort. Clients who are able to seek primary care and HIV specialty services from other providers or through other payors must do so. Services provided with RWHAP funding "complete" coverage to ensure the highest-quality care and best prognosis for all people living with HIV.

Primary medical care for the treatment of HIV infection includes providing care that is consistent with the Public Health Service's guidelines. This care must include access to antiretroviral (ARV) and other drug

therapies, including preventative therapies, treatment of opportunistic infections, and combination ARV therapies.

Client medication uptake support services (Treatment Adherence) provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category, while client medication uptake support services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

REQUIREMENTS

All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to adhere to the following standards:

PROVIDER QUALIFICATIONS AND OVERSIGHT:

To provide RWHAP Outpatient/Ambulatory Health Services, health care professionals must:

- Maintain a current and valid MD, DO, PA, or NP state licensure, and
- Provide access to appropriate antiretroviral therapy (ART) and treatment for opportunistic infections for patients, and partner services.

KEY ACTIVITIES

INITIAL INTAKE VISIT:

- **Screening and Eligibility:** At the initial intake visit for a new client in this service category, staff must screen for Medi-Cal or other available healthcare payment sources and verify eligibility, either directly or through the referring provider. This process ensures the client can access the most comprehensive payment source and preserves RWHAP funds as the payor of last resort. All eligibility screening and enrollment in coverage must comply with the procedures outlined in the Universal Standards of Care.
- **Health History:** After eligibility screening, the provider must conduct a health history assessment, which includes:
    - History of HIV diagnosis, including date and believed route of transmission
    - Vital signs and baseline body weight measured for normal weight and height without shoes
    - Full medical history, including history of anal pap smears for both men and women
    - Documentation of sexual history (sexual practices, number of partners, past STIs and current methods of protection, pregnancy history and future pregnancy plans
    - Contact information for referring or recent care providers
    - Current medications and any recent changes in regimen
    - The status of vaccinations, including dates of pneumonia (current Prevnar 20), meningococcal, Hepatitis A & B, varicella zoster (shingles), HPV, influenza, TDAP (tetanus, diphtheria, and pertussis), COVID-19 vaccination and boosters, mpox vaccine (JNNEOS), and other currently recommended vaccinations
    - Documentation of any known medication allergies
    - Current and past alcohol, tobacco, and other substance use
    - For clients assigned female at birth, a detailed reproductive history including history of menses, contraceptive methods, pregnancy and childbirth, and Pap smear results. Healthcare

providers are expected to advise and provide these patients with a Pap test for screening of cervical cancer within one year of onset of sexual activity, but no later than 21 years of age

- Laboratory data, including:
  - CD4 and HIV viral load
  - Genotype/phenotype (if indicated)
  - An interferon gamma release assay such as QuantiFERON-TB Gold, or PPD if an interferon gamma release assay is not possible for financial or logistical reasons.
    If the test is positive, a chest x-ray is required.
    - ❖ If the x-ray is negative for active TB, latent therapy must be given.
    - ❖ If the patient misses the appointment for the assay, the appropriate follow-up activity should be performed and documented.
  - Hepatitis A, B, and C screening
  - Complete Blood Count (CBC) with platelets
  - Comprehensive metabolic panel
  - Complete lipid panel (cholesterol and triglycerides)
  - STD screening for syphilis, gonorrhea, and chlamydia
  - HLA-B*5701 can be conducted at baseline or when considering an abacavir (ABC)-containing regimen to reduce the risk of hypersensitivity reaction to ABC.
    - ❖ Patients who are HLA-B*5701 positive should not be prescribed an ABC- containing ART regimen. Documentation of ABC allergy must be included in the patient medical record.

- **Antiretroviral Therapy (ART):** ART is recommended for all patients living with HIV. Use the recommended ART regimens for ART-naïve patients for newly diagnosed patients in addition to those who were previously diagnosed and have never initiated ART. Patients should be counseled on adherence. Incomplete adherence can result from complex medication regimens, active substance abuse, depression, the experience of medication side effects, and health system issues that lead to interruptions in patient access to medication and inadequate treatment education and support. Assess for factors that may serve as a barrier to adherence and discuss ways to maximize adherence before and after initiation of ART. United States Department of Health and Human Services Guidelines should be used as a resource in determining the appropriate treatment for each patient. Treatment for pregnant persons should follow the *Guidelines for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States*. The client's health status should be prioritized.

- **Viral load (VL) and CD4 count** should be measured regularly, at diagnosis and every 3-6 months thereafter.
  - Suppressed viral load is considered as a confirmed viral load of <200 copies/mL. Note that individuals who are consistently taking their ART regimen and do not harbor resistance mutations to components of the ART can generally achieve viral suppression 8 to 24 weeks after ART initiation.
  - A screening of any potential barriers that may affect adherence to medications and treatment must be performed at intake as well as at follow-up visits (e.g., lack of housing, mental health issues, etc.).

- Once the appropriate treatment is determined by the medical provider and client, that treatment or therapy should be initiated using the most current Department of Health and Human Services (DHHS) guidelines https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-arv/guidelines-adult-adolescent-arv.pdf
- Baseline resistance testing (protease and reverse transcriptase) is required for all new starts. Baseline integrase sequencing is required for patients with prior use of long-acting cabotegravir for PrEP or prior INSTI-based PEP.
- There must be documentation in the patient's medical record of discussions regarding medication(s) side effects, dosing schedule and related adherence issues by the time treatment is initiated.
- For clients who have >2 years of viral suppression and CD4 counts between 300-500, VL and CD4 measurements can be done annually
- For clients whose CD4 measurements are consistently >500, CD4 measurement is optional.

- **Mental Health and Substance Abuse:** Providers must screen all new clients using standardized mental health and substance use screening tool(s). Referrals to mental health or substance abuse providers must be made promptly using a "warm hand-off".

- **Partner Notification:** Providers must discuss and offer are required to offer Partner Services to all clients. These services help clients disclose their HIV status to sexual or needle-sharing partners, reduce the risk of forward transmission, and give partners the opportunity to receive HIV testing and be linked to appropriate care.

- **Treatment Plan:** Before the close of the intake visit, the medical provider and client must jointly discuss and agree on a Treatment Plan. The purpose of the Treatment Plan is to guide the provider in delivering high-quality care corresponding to the client's level of need, including the determination of emergency vs. non-emergency care, triage care, and referral as needed. With "patient-centered" treatment planning, the clinician's plan will be listed with notes as to which treatments will be delivered (per client's consent) and how referrals will be made and tracked. The Treatment Plan must include the method(s) of communication between all providers and the client. It is best practice to obtain agreement to the treatment plan between the medical provider and client. The client record should contain documentation that the treatment and care plan was discussed and that the client expressed agreement to the plan.

- **Problem List:** In addition to the Treatment Plan, the provider is responsible for discussing and developing a Problem List. This list clearly prioritizes problems for primary care management and is kept separately from progress notes. All problems should be listed and dated. The Problem List must also identify:
  - History and activity of mental health and substance-abuse disorders, and the integration of treatment for these conditions with the HIV primary medical care
  - The provider of other continuing health care (e.g., mental-health or substance abuse service provider, or other continuing specialty service) and its location, if different from the outpatient ambulatory health services site.
  - The provider of case management services, if different from the outpatient ambulatory health services site.

- A list of medical diagnoses should be updated in the client's record as a summary of the client's past medical history.

- **Charting:** At the close of the intake visit, the client's record must contain a complete and signed Treatment Plan, Problem List, and list of medications (if applicable).

Core Performance Measures:

Linkage to Care	Was the client linked or relinked to care in 30 days or less?
Rapid ART	Was the client prescribed ART at their first medical visit?
Retention in Care	Did the client have 2 medical visits at least 90 days apart in the last 12 months?
Viral Suppression	Did the client reach an HIV viral load of <200 copies/mL at their last test?

FOLLOW-UP VISITS:
Follow-up visits are recommended every three to four months for patients on a stable ART regimen. For some patients who are doing well for long periods of time with long-standing undetectable viral load, the follow-up can occur every six months. All patients should have at least 2 visits per year.

- **Status and Updates:** Follow-up visits should always record and address:
  - Temperature, vital signs, and weight (for in-person visits)
  - Problem list status and updates
  - Any changing need for support around partner notification (Partner Services).

- **Consistency with Treatment Plan and Update:** Client consistency with the Treatment Plan should be assessed and reinforced at each visit, with changes made to the Treatment Plan as needed. Any changes to the Treatment Plan must be agreed to by both provider and client.

- **Resistance Testing:** If practical, resistance testing should be performed for all clients at baseline. If not performed on all clients, resistance testing should be performed when virologic failure to ART has been demonstrated and/or when viral load suppression is not as expected after initiation of therapy, or in the case of virologic failure after suppression. Resistance testing is recommended as a tool for selecting active drugs when changing ART regimen because of virologic failure. Drug-resistance testing in people with plasma viral loads <200 copies/mL is not recommended since drug-resistance assays cannot be consistently performed at very low HIV-RNA levels. The most recent DHHS guidelines must be followed when changing therapy. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/drug-resistance-testing

- **Prophylaxis:** Prophylaxis of opportunistic infections (OI) should be offered to each client at the appropriate CD4 count. Refer to Guidelines for prophylaxis of OI in the DHSS Guidelines for the use of Antiretroviral Agents in Adults and Adolescents with HIV and guidelines at https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new and https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/adult-adolescent-oi/guidelines-adult-adolescent-oi.pdf. Documentation of current therapies should be maintained on all patients receiving prophylaxis.

- When the CD4 count drops below 50, the patient should have an **ophthalmic examination** by a trained retinal specialist at least once every six months.

- **Laboratory Testing:**
  - Tuberculosis: Conduct a TB screening annually for persons who may have been at risk for any of these infections.
    - Conduct an interferon gamma release assay at baseline or chest x-ray every five years if the client has a previous positive result.
    - Repeat testing if medically indicated.
  - STIs: Syphilis serology, and screening for gonorrhea, chlamydia and trichomonas for persons who may have been at risk for any of these infections.
    - Repeat testing, if medically indicated.
  - Hepatitis C
  - Clients assigned female at birth should have a pap smear.
    - Smears showing severe inflammation or reactive changes should be reevaluated within three to six months.
    - Diagnosis of squamous intraepithelial lesions (SIL) or atypical squamous cells of undetermined significance should be followed with colposcopic examination of the lower genital tract.
    - Inquire about LMP and contraception, when appropriate.
  - For persons engaging in anal sex, discuss the option of an anal Pap smear to screen for HPV in accordance with DHSS guidelines. Screening is recommended for adults 35 years and older who have HIV and are cisgender men who have sex with men, transgender women, women, transgender men who have sex with men and other populations indicated by the guidelines. Clinicians should perform or recommend anal Pap testing to identify potentially cancerous cytologic abnormalities.
- **Education:** At least once per year, all clients should receive primary health care education provided in a language and at a literacy level appropriate to the client. Primary health care education must be documented in the client's record, and should include the following components:
  - Prognosis/progression of HIV
  - How HIV is transmitted, and behaviors that put others at risk for transmission of HIV (Prevention for Positives)
  - How to interpret lab results
  - Indications for treatment, goals for treatment, general information regarding side effects of treatment, treatment options, insurance/payment options, and the availability of medication adherence support programs
  - Smoking cessation and the interactions between smoking and HIV
  - Partner Services options (HIV status disclosure assistance)
  - Partner HIV prevention education
  - Nutrition information
  - Oral health information
  - Vision screening resources
  - Information on the latest research relevant to the client
  - Substance use treatment and support resources
  - Support groups and other available psychosocial support services

- **Advance Planning:** Advance directives, durable powers of attorney, living wills and other planning documents, including "Do Not Resuscitate" (DNR) orders and status and permanency planning for dependent children, should be addressed at the beginning of ARV treatment and at any appropriate time throughout the course of follow-up visits.

- **Reportable Illnesses:** All reportable illnesses identified during follow-up visits must be reported to the local health department and included in chart documentation.

SERVICE CHARACTERISTICS:

- An on-call clinician who provides medical advice must be available to clients by phone 24 hours/day, 7 days/week, 365 days/year.
- Initial clinic visits must be available to new patients within two weeks of scheduling.
- Urgent clinic visits must be available to new patients within 3 days of scheduling.
- In cases of emergency, patients must be assisted in determining whether their symptoms indicate the need for emergency care and informed of how to access 24-hour emergency care.
- Primary health care site staff must maintain referral relationships with key points of entry within and outside of the HIV services system to ensure newly diagnosed clients who are not currently in care are rapidly referred. Key points of entry include, but are not limited to:
    - Emergency rooms
    - Inpatient hospital settings
    - Counseling and testing sites
    - Substance use treatment programs
    - Homeless shelters and single room occupancy (SRO) hotels
    - Community-based case management providers
- Primary health care activities should be provided as part of a care team, including a medical case manager and other providers as appropriate. Case conferencing by the care team to discuss client progress with the Treatment Plan and other health indicators is required at least once per month.
- Providers must have a documented plan to follow up with clients who miss initial appointments.
- Providers must have a documented plan to follow up and re-link out of care clients to primary care services.
- Providers must use standard "new client" information packets that include:
    - Patient Rights and Responsibilities
    - Grievance Procedures
    - Availability of mediation services
    - Information on ADAP
    - Risk reduction information
    - Other county-specific information as appropriate

PREFERRED PROVIDER QUALIFICATIONS

To provide services in this service category, providers should:

- Have experience providing direct, continuous, ongoing care for patients living with HIV over the previous two years, or be supervised onsite by an experienced clinician who meets this criterion.
- Complete at least 30 hours of HIV-related CME Category One credits over the previous two years, including opportunities provided by the AIDS Education and Training Center (AETC)
- Successfully complete the American Academy of HIV Medicine (AAHIVM) Credentialing or the Advanced HIV/AIDS Certified Registered Nurse (AACRN) examination.

- Clinical support staff, if not HIV-certified, must receive in-service and/or continuing education appropriate for their position, on topics related to HIV care.

RECOMMENDED BEST PRACTICES:
For patients with a viral load between 500–1,000 copies/mL where standard testing is unfeasible, proviral DNA next-generation sequencing should be considered to identify archived mutations.

Resources:
Adult and adolescent ARV Guidelines: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new

CDPH Dear Colleague Letter (March 2, 2026):
https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/DCL-Ordering-HIV-Genotypes.pdf

Outreach Services – Support Service

INTRODUCTION

This document describes the "Outreach Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Outreach Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION

Outreach Services are activities that are focused on identifying people with HIV who either do not know their HIV status, or who know their status but are not currently in care. Outreach Services providers offer the following activities: 1) identification of people who do not know their HIV status and/or 2) linkage or re-engagement of people with HIV who know their status into HIV care services, including provision of information about health care coverage options and enrollment into health coverage as appropriate.

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

PURPOSE/GOALS

To assist clients and their significant others with developing and achieving their outreach goals. These services will address crises and stabilize clients' outreach status in order to promote health care maintenance and positive health outcomes.

SERVICE CHARACTERISTICS

Outreach Services must include the following components:

- Use data to focus on populations and places that have a high probability of reaching people with HIV who
  a) Have never been tested and are undiagnosed,
  b) Have been tested, diagnosed as HIV positive, but have not received their test results, or
  c) Have been tested, know their HIV positive status, but are not in medical care
- Be conducted at times and in places where there is a high probability that people living with HIV will be identified
- Be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

Services: Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available HRSA RWHAP services. Ultimately, HIV-

negative people may receive Outreach Services and should be referred to risk reduction activities. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services.

Program Guidance: Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care. Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when HRSA RWHAP resources are available and where the testing would not supplant other existing funding**.**

Psychosocial Support Services – Support Service

INTRODUCTION

This document describes the requirements and standards that apply to the "Psychosocial Support Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Psychosocial Support Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION:

Psychosocial Support Services are defined as:

- Counseling and support activities that are conducted in an individual or group setting, led by a licensed clinician or by an RWHAP medical or non-medical case manager with appropriate education, training and experience
- Services that are time-limited and that may be provided in person or virtually, i.e., via videoconferencing or an equivalent telehealth delivery system, and may include:
  - Peer-facilitated support groups that address the needs and concerns of people living with HIV, led by trained facilitators
  - Vocational counseling in an individual or group setting
  - Nutrition counseling provided by a non-registered dietitian (must not include the provision of nutritional supplements)
  - Caregiver support activities, which may include pastoral care, bereavement counseling, or counseling pertaining to parenting and/or dependent care.

REQUIREMENTS:

All subrecipient agencies receiving funds to provide services under this RWHAP service category are required to provide psychosocial support services designed to address the needs and interests of special population groups in the TGA. Psychosocial support groups must be open to any person living with HIV. In addition, subrecipient agencies are required to adhere to the following standards:

FACILITATOR/PROVIDER QUALIFICATIONS:

Facilitators must have the knowledge, skills and experience necessary to facilitate psychosocial support groups and to provide individual psychosocial support services.

- Services may be provided by licensed clinicians, pre-licensure interns, students with appropriate supervision, and/or RWHAP medical or non-medical case managers with appropriate training.
- Peer support group facilitators and peer counselors must be individuals who are living with HIV, or have related lived experience, and must be trained in counseling practices and peer support group facilitation.

ALLOWABLE SERVICES:

RWHAP Psychosocial Support Services include the following:

- Individual and/or group counseling that is designed to move clients toward identified goals

- Psychosocial support groups that are structured around a specific curriculum, or that explore a specific topic
- Psychosocial support services that are provided on a drop-in basis, including support offered in crisis situations
- Nutrition counseling for clients living with HIV, which includes health education and nutritional guidance, but does not include the provision of nutritional supplements
- Emotional support groups for caregivers who have a documented relationship to a person living with HIV, with participation limited to 12 sessions in a ten-month period
- Pastoral care that is provided in a group setting and limited to 8 sessions in a three-month period per fiscal year
- Bereavement counseling that is offered in a group setting and limited to 8 sessions in a three-month period per fiscal year.

SUPPORT, REFERRAL AND COORDINATION OF SERVICES:
Psychosocial Services are part of the coordinated continuum of care and should be designed to promote linkage and retention in HIV care.

- Staff with appropriate training and experience should provide immediate support and referrals for urgent situations. In crisis or emergency situations, including violent or suicidal behavior, crisis interventions must only be provided by licensed clinical staff who are working within their clinical competency and scope of practice.
- Psychosocial support services should be made available to clients who are also receiving medical or non-medical case management services, mental health services, and/or substance abuse outpatient services.
- Clients should be referred to other appropriate services when needed.
- Clients not currently accessing medical care should be referred to a primary care provider.

RECOMMENDED BEST PRACTICES:
Recipient agencies should actively recruit and train qualified individuals who are living with HIV or have related lived experience.

Referral for Health Care and Support – Support Service

INTRODUCTION

This document describes the "Referral for Health Care and Support Services" category of support services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Referral for Health Care and Support services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements

SERVICE DEFINITION

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

PURPOSE/GOALS

The goal of Referrals for Health Care and Support Services is to minimize crisis situations and stabilize clients in order to maintain their participation in primary care and support services.

Referrals provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals provided by case managers (medical and non-medical) should be reported by the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Referral for Health Care and Support funds cannot be used to duplicate services provided through other service categories.

REQUIREMENTS

All subrecipient agencies receiving funds to provide services under this RWHAP service category must adhere to the following standards:

- Referrals for Core Medical and Support Services provide clients with assistance in accessing medical and support services to improve engagement in the health care system and the HIV continuum of care.
- Staff shall possess the ability to provide developmentally and culturally appropriate services to people living with HV. Staff must demonstrate a sensitivity to LGBTQ, housing instability, and HIV issues and associated stigma.

KEY ACTIVITIES

Key activities of Referral for Health Care and Support Services include:

- **Screening and Assessment:**
    - Service providers shall conduct a screening of the client's needs and eligibility in order to facilitate the referral process or assistance in applying to benefits the client may be entitled to, including Medi-Cal or other payment sources.
    - Clients must be assessed to determine needs including, but not limited to:
        - Benefits counseling and insurance coverage
        - Medical care including HIV care, primary care and medical referrals
        - Adherence to medication and appointments
        - Mental health including the need for psychiatry and psychotherapy
        - Substance use history and need for substance use treatment and addiction support
        - Health education, health promotion and disease prevention
        - Usage of core and support Ryan White services
        - Sexual health behaviors
        - Family make-up
        - Evaluating and improving social and community support systems
        - Housing navigation assistance
        - Transportation coordination
        - Risk reduction counseling
        - Partner notification and disclosure
        - Environmental and interpersonal safety
        - Legal support
        - Access to food resources and nutritional assessment
        - Dental care
        - Language and cultural needs
        - Financial assistance, including emergency financial aid
        - Spiritual care
- **Referral to Services:** Clients should be referred to services as needed based on their needs assessment. Referrals should be documented. Staff should follow up to ensure that each client was connected to services.
- **REASSESSMENT:** Face-to-face reassessments will be performed as clients complete their goals, or as needs change and additional resources and providers are indicated.
- **DISCHARGE/CASE CLOSURE**: A file should be closed when there has been a request for closure or when there has been no client contact for over 6 months**.**

Substance Abuse Outpatient Services – Core Service

INTRODUCTION

This document describes the "Substance Abuse Outpatient Services" category of core medical services under the RWHAP. Subrecipient agencies that receive RWHAP funds to provide Substance Abuse Outpatient Services must adhere to the Universal Standards of Care as well as the requirements that are set forth in the Standards of Care for this service category. The Standards of Care for this service category consist of the following:

- Service Definition
- Program Requirements
- Recommended Best Practices

SERVICE DEFINITION

Substance Abuse Outpatient Services are medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting. They may be provided by a physician, under the supervision of a physician, or by other qualified personnel.

Substance abuse services may involve a variety of mental, emotional, spiritual, and practical skills to deal with addictions and ongoing recovery, as well as clinical treatments and interventions that address the physical causes and symptoms of addiction.

PURPOSE/GOALS

To assist clients with HIV and their significant others, including family and friends, in coping with the physical and psychological manifestations of addiction to alcohol, tobacco, and other drugs, and to assist clients in abstaining from substance use or reducing use through harm reduction strategies.

Provision of these services will minimize crisis situations and stabilize client substance use in order to maintain their participation in primary care and support services.

REQUIREMENTS

All subrecipient agencies receiving funds to provide services under this RWHAP service category must adhere to the following standards:

PROVIDER QUALIFICATIONS AND OVERSIGHT:

To provide services in this service category, providers must maintain a current and valid licensure where appropriate:

- **PSYCHIATRIST:** MD state licensure
- **PSYCHOLOGIST:** PhD or PsyD state licensure
- **PSYCHIATRIC NURSE:** California state licensure
- **CLINICIAN:** MFT, LCSW
- **REGISTERED CLINICAL OR STUDENT INTERNS:** Appropriate supervision
- **CERTIFIED CALIFORNIA ALCOHOL AND DRUG ABUSE COUNSELOR (CADAC):** Certification

Providers must demonstrate a sensitivity to treatment options

- Abstinence vs. harm reduction
- Residential vs. outpatient

Providers must demonstrate a sensitivity to LGBTQ+/homelessness issues/stigma and HIV issues/stigma
Providers must understand cultural identity, particularly as it relates to substance use

KEY ACTIVITIES
Key activities of Substance Abuse Outpatient Services include:

- **Screening and Assessment:**
  - Clients must be screened for Medi-Cal or other payment sources
  - Complete a comprehensive substance abuse assessment:
    - Current and past substance abuse
    - Current medications and side effects
    - Impact and client's understanding of significance
    - Must include an Addiction Severity Index, Substance Abuse Mental Illness Symptom Screener (SAMISS), Addiction Severity Assessment Medical (ASAM), Drug Dependence Screen (DDS), simple screening instrument or other acceptable assessment tool
    - Comprehensive Substance Use Biophysical Assessment
  - Client must be seen by a licensed clinician for a comprehensive medical exam within 30 days of intake (medical treatment programs only)
- **Treatment Plan Development and Implementation:** the provider will develop a treatment plan based on the comprehensive assessment within 30 days.
  - Treatment plan should be created with input from clients
  - Treatment plan should be updated every 90 days
  - A variety of culturally and linguistically sensitive and evidence-based treatments must be made available
- **Support, Referral and Coordination of Services:** Services are part of the coordinated continuum of care. Staff provides immediate support and referrals for urgent, crisis, and emergency situations, including violent or suicidal behavior**.**
  - Substance Abuse Outpatient Services staff should provide appropriate referrals when clients have acute substance abuse needs that fall outside of the scope of the funded services or competency of the clinician
  - Clients should be referred to support groups, when appropriate
  - Clients not currently accessing medical care must be referred to a primary care provider

- Clients in need of housing should be referred to Non-Medical Case Management services or another appropriate provider to assist with accessing housing resources

- **REASSESSMENT:** Face-to-face reassessments will be performed as clients complete their goals, or as needs change and additional resources and providers are indicated.
- **DISCHARGE/CASE CLOSURE**: A file should be closed when there has been a request for closure or when there has been no client contact for over 6 months**.**

RECOMMENDED BEST PRACTICES

GENERAL SERVICES CHARACTERISTICS, WHENEVER POSSIBLE

ENGAGEMENT AND RETENTION: Agencies are strongly encouraged to develop and maintain a strong and consistent method for engaging and retaining clients during outreach and testing activities, as those clients most likely to benefit from Substance Abuse Outpatient Services are also those who are most difficult to retain in ongoing services, linkage, and follow-up.