



Wisconsin
Department of Health Services

Linkage to Care Specialist Program Manual

A Patient Navigation Program for People Living with HIV and AIDS

Health Resources and Services Administration, HIV/AIDS Bureau,
Special Project of National Significance: Systems Linkages and Access to
Care for Populations at High Risk of HIV Infection (2011-2015)

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INTRODUCTION

This manual describes lessons learned from Wisconsin's participation in a national initiative to develop novel systems of HIV care. These novel systems of care were designed to improve access to and retention in high quality HIV medical care for hard-to-reach populations of people living with HIV and AIDS (PLWHA). The initiative was funded by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) as a Special Projects of National Significance (SPNS) program from 2011-2015¹. This Systems Linkages initiative was implemented by six demonstration sites across the United States. An evaluation and technical assistance center (ETAC) housed at the University of California-San Francisco coordinated the multi-site evaluation and provided technical assistance to the sites. This SPNS initiative was structured according to the Institute for Healthcare Improvement's Collaborative Learning Model², in which the first two years of the initiative were designed to develop, pilot and refine novel programs, and the second two years were for wider-scale implementation and evaluation.

The overall goal of the SPNS Systems Linkages initiative was to improve access to and retention in high quality HIV care for individuals unaware of their HIV status, those receiving medical care but not HIV care, those who entered HIV care but later dropped out of care, and sporadic or infrequent users of HIV care. The primary outcomes of this SPNS initiative are to increase the number of:

- Individuals living with HIV who know their serostatus,
- Newly diagnosed people linked to care within three months of diagnosis,
- Individuals living with HIV who are virally suppressed, and
- Individuals living with HIV retained continuously in high-quality HIV medical care.

Wisconsin had two initiatives as part of the SPNS Systems Linkages initiative. The first initiative was to develop a new patient navigation program and the second was to improve an existing Social Networks Testing. The Social Networks Testing program is described in a separate manual.

The purpose of this manual is to provide an overview of the patient navigation program developed as part of the SPNS Systems Linkages initiative and to offer program planning and implementation information to other HIV providers interested in adapting or replicating a similar program for PLWHA in their community. This manual is organized into four sections: Background, Linkage to Care Specialist Program Overview, Replicating the Linkage to Care Specialist Program, and Lessons Learned. The Background section contains a brief description of the Linkage to Care Specialist (LTCS) program and the epidemiology of HIV in Wisconsin. The Linkage to Care Specialist Program Overview section outlines the

¹ Announcement HRSA-11-098

² Institute for Healthcare Improvement. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. IHI Series white paper, 2003. Available at www.IHI.org.



goals and key elements of the LTCS program. The section on replicating the LTCS intervention reviews models of care among participating agencies, leveraging existing systems of care, staffing, training and monitoring requirements. The Lessons Learned section describes how the program evolved over time and successes and challenges encountered during implementation.



BACKGROUND

DESCRIPTION OF LINKAGE TO CARE SPECIALIST PROGRAM

One of the key strategies in Wisconsin’s plan to improve engagement in HIV care across the care continuum is the development of a new position known as a Linkage to Care Specialist (LTCS). The LTCS serves as a patient navigator, providing short-term, intensive case management and care coordination services aimed at assisting clients in identifying and overcoming barriers to accessing and maintaining engagement in HIV medical care.

Client Quote: *“I think I learned enough from her and you know... I don’t want to disappoint and I know that I need to maintain my health ... now that I have my home or my apartment I can put a calendar up on my refrigerator and mark those dates. I’m comfortable and I can do it on my own.”*

Because each client has a unique set of barriers, the individual tasks performed by the LTCS cannot be defined as a specific set of services. Through this client-centered approach, the LTCS provided the client with the knowledge and skills necessary to actively participate in their healthcare, and to maintain engagement in care and adherence to treatment after discharge from the LTCS program.

The LTCS works with five client populations: newly diagnosed, new to care, out of care, post-incarcerated, and at risk. The five client types are defined below.

ELIGIBLE CLIENT TYPES

1. **Newly Diagnosed:** clients first diagnosed with HIV infection during the previous 90 days.
2. **New to Care:** clients previously diagnosed (more than 90 days ago) with HIV infection but not previously linked to HIV medical care.
3. **Out of Care:** clients who have not attended an HIV medical visit during the previous six months.
4. **Post-Incarcerated:** clients previously diagnosed with HIV infection who are referred by and recently released from a Wisconsin Department of Corrections (DOC) institution.
5. **At-Risk:** clients who meet one or both of the following criteria:
 - a. Have missed two or more consecutive HIV medical appointments, and/or
 - b. Have a detectable viral load while on HIV treatment.



The LTCS and the client identify barriers that have prevented or may prevent the client from linking to or engaging in HIV medical care and the LTCS addresses these barriers through a standardized process including intake, assessment, service plan development and implementation, transition planning, and discharge.

The LTCS program is designed to be a time-limited service that prepares clients to maintain engagement in HIV medical care through case management or self-management. The LTCS works with the client for up to nine months. During that period the client must attend at least three HIV medical visits with a prescribing provider prior to discharge. At intake, the client should be made to understand the time-limited nature of LTCS services and that the goal for the client following LTCS discharge is to continue engaging in HIV medical care by transitioning to self-management or case management services.

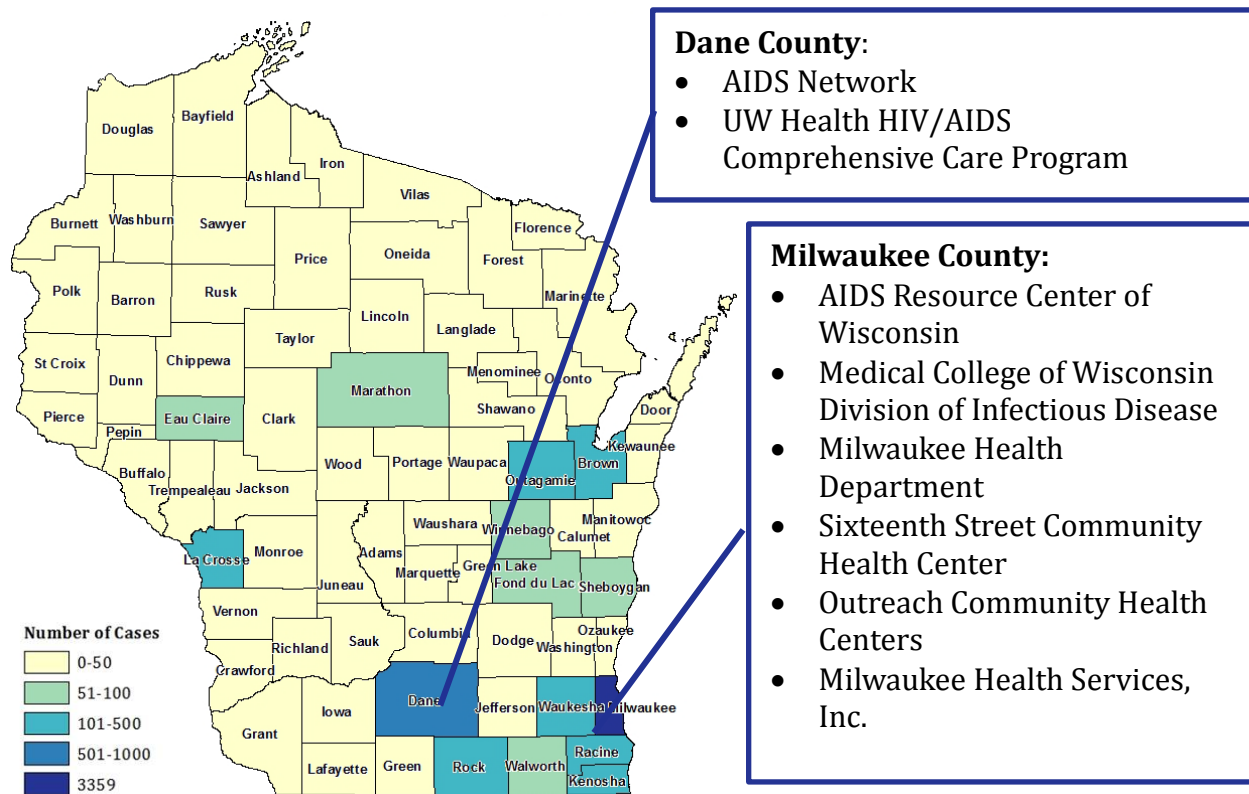
DESCRIPTION OF NEED

Wisconsin is a low-to-moderate HIV morbidity state, with a 2014 HIV diagnosis rate of 4/100,000 and a 2014 prevalence rate of 121/100,000. However, within Wisconsin are geographies and populations with diagnosis and prevalence rates that are comparable to other heavily impacted populations nationwide. For example Milwaukee County, which accounts for just 17 percent of the state's population but half of all new diagnoses and prevalent cases, has an HIV diagnosis rate of 14/100,000 and a prevalence rate of 353/100,000.

The LTCS program is focused in Wisconsin geographies with the greatest number of new diagnoses and prevalent cases, which include Milwaukee and Dane counties and their surrounding areas (Figure 1). The HIV care continuum for these counties, as well as Wisconsin as a whole, is shown in Figure 2. While linkage to care within 90 days is high, the significant drop in the proportion of individuals with one or more medical visits during 2014 suggests that linkage may be tenuous and does not necessarily result in subsequent adherence to care. In fact, only two-thirds of prevalent cases had one or more medical visits and even fewer were considered retained in care. This leaves just half of all PLWHA in Wisconsin with suppressed viral load. In addition to worse HIV-related health outcomes, those not engaged in care miss opportunities for connections to other supportive services such as mental health and housing.



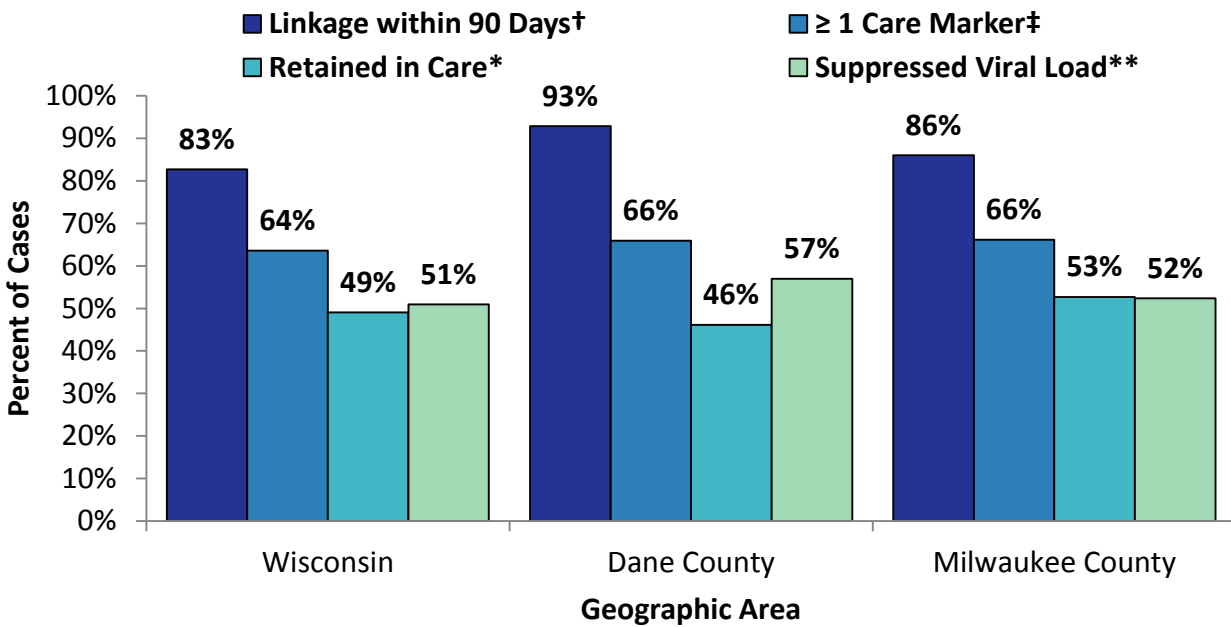
Figure 1. Reported cases of HIV infection presumed to be alive by county as of 12/31/2014 and Linkage to Care Specialist locations, Wisconsin³



³ AIDS Network merged with the AIDS Resource Center of Wisconsin in February 2015. The agencies are treated separately throughout this manual as they were separate entities during the majority of the LTCS program implementation.



Figure 2. Wisconsin HIV care continuum: 2013 new diagnoses and care during 2014 among 2013 prevalent cases



†At least one CD4 or viral load test result in the HIV surveillance system between 1 and 90 days after the earliest known HIV diagnosis date; ‡At least one CD4 or viral load test result in the HIV surveillance system during the measurement year; *Two or more CD4 or viral load test results in the HIV surveillance system, at least 3 months apart, during the measurement year; **Last viral load test result during the measurement year <200 copies/mL

Low levels of engagement in HIV care and viral suppression, in addition to other factors, have led to an increase in HIV diagnoses among young men who have sex with men (MSM), primarily in Milwaukee. While the number of new diagnoses has declined or remained stable for older men and women of all ages, new diagnoses among males 13-29 years of age has increased by about 50 percent. Even more alarming is the doubling of new HIV diagnoses among young Black MSM over the decade (2005-2014). Other factors contributing to increased transmission among young MSM, many of which are also barriers to HIV care, may include:

Low Socioeconomic Status: Many of the top zip codes of residence for people newly diagnosed with HIV in recent years have indicators of low socioeconomic status, including low income and educational attainment.

High HIV Prevalence: Using the current number of new HIV diagnoses among Black MSM, the estimated proportion of individuals who are unaware of their HIV infection, and the estimated proportion of MSM in Wisconsin, we estimate the HIV prevalence among Black

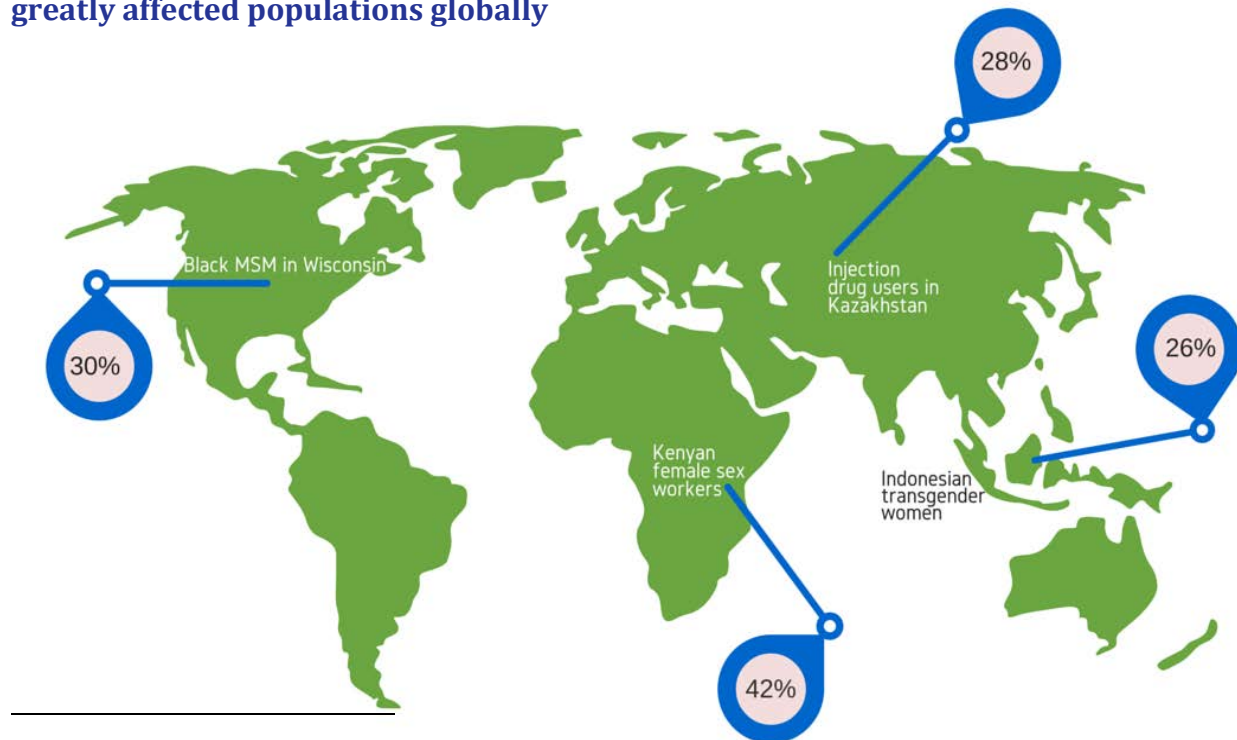


MSM to be 30 percent, similar to other greatly impacted populations worldwide (Figure 3)⁴.

Anti-Gay Stigma: An epidemiologic investigation conducted in 2009 by the Centers for Disease Control and Prevention (CDC) in partnership with the AIDS/HIV Program and several Milwaukee-based agencies found that there is significant anti-gay stigma that appears to affect young Black MSM more than other racial/ethnic groups. This anti-gay stigma ultimately contributes to risky sexual behaviors and situations, lack of HIV disclosure to partners, lack of knowledge about HIV risk and maladaptive coping (alcohol, drugs, etc.), which not only increases the likelihood for HIV transmission, but also reduces the likelihood of engagement in medical care.

Unknown HIV status: Young Black MSM may be the most likely to be unaware that they are infected⁵. According to the CDC, 51 percent of HIV infected individuals ages 13-24 and 15 percent of Blacks are unaware of their HIV status⁶.

Figure 3: Percentage of Black MSM living with HIV in Wisconsin compared to other greatly affected populations globally



⁴ Foundation for AIDS Research Issue Brief. HIV and the Black Community: Do #Black (Gay) Lives Matter? February 2015. Available at: http://www.amfar.org/uploadedFiles/amfarorg/Articles/On_The_Hill/2015/Black%20Gay%20Men%20and%20HIV.pdf.

⁵ CDC. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—five U.S. cities, June 2004-April 2005, Morbidity and Mortality Weekly Report (MMWR) 2005; 54(24):597-601. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5424a2.htm>.

⁶ Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas—2012. *HIV Surveillance Supplemental Report* 2014;19(no.3). <http://www.cdc.gov/hiv/library/reports/surveillance/>. Published November 2014. Accessed April 2015.



LINKAGE TO CARE SPECIALIST PROGRAM OVERVIEW

The Linkage to Care Specialist program began in April 2012 with the hiring of ten new Linkage to Care Specialists to be placed at Ryan White funded agencies in Southern Wisconsin. The LTCS protocol was drafted and piloted between April 2012 and September 2014. The final protocol is attached as Attachment A. The protocol is a result of several Plan-Do-Study-Act (PDSA) cycles and formal and informal feedback based on the successes and challenges encountered during implementation. Included below are several excerpts from the protocol that describe goals, core elements and key milestones.

GOALS

The goals of the LTCS program, consistent with the overall SPNS Systems Linkages goals, are to increase overall levels of client engagement in HIV medical care, including both timely linkage and retention, and to increase the number of PLWHA in Wisconsin who are virally suppressed. The short-term objectives are for the client to attend at least three HIV medical visits over the course of nine months while enrolled in the LTCS program, and to increase independence and transition to self-management or case management after completion of the LTCS program.

CORE ELEMENTS

Target Populations

There are five client populations eligible to participate in the LTCS program. Given that the LTCS program does not rely on an acuity scale to determine client eligibility, the LTCS ensures that referred clients meet these criteria and if not, makes appropriate referrals to case management.

- 1. Newly Diagnosed:** client was first diagnosed with HIV infection during the previous 90 days and has not yet received HIV-related medical care. In addition, the client must have at least one other complicating factor, such as homelessness or mental health barrier.
- 2. New to Care:** client was first diagnosed with HIV infection more than 90 days ago and has never received HIV-related medical care, or the client was first diagnosed with HIV infection more than 90 days ago and is transitioning from pediatric to adult HIV medical care.
- 3. Out of Care:** client was first diagnosed with HIV infection more than 90 days ago and has received HIV medical care previously but has not attended an HIV medical appointment in the previous six months.
- 4. Post-Incarcerated:** client is infected with HIV and is incarcerated in a Department of Corrections (DOC) facility with a scheduled release date within six months and



will be released to an eligible LTCS service area. The DOC maintains Wisconsin's state prison system, which does not include county jails or other short-term correctional facilities.

5. **At-Risk:** client was previously diagnosed with HIV infection and has missed two or more consecutive HIV medical appointments and/or has detectable viral load while on antiretroviral medication.

Key Components and Milestones

Summarized below are the main protocol sections, including any standards described in the protocol.

- **Referrals:** The protocol provides flow diagrams illustrating the steps and timeframes required for making a referral to an LTCS from the most common referral sources, including Partner Services, HIV testing sites, clinics, and the Wisconsin Department of Corrections. Also included is a process flow for the LTCS to contact referred clients and enrolled clients with whom they have lost contact.
- **Collaboration and Case Conferencing:** Collaboration between the LTCS and other providers working with the client is imperative in order to achieve the stated goals and avoid service duplication. Outlined within the protocol are communication expectations between the LTCS and the referral source, the client's HIV care team, and the post-LTCS discharge case manager, if applicable.
- **Client Communication:** Communication between LTCS clients and their specialist is frequent. The protocol outlines communication standards for client contact, including minimum face-to-face contacts and encounters in varied settings, including at least one home visit.
- **Intake and Assessment:** In most cases, intake occurs during the initial meeting with the client. During intake the LTCS explains the scope of LTCS services and expectations for client participation in the program. The LTCS gathers information on the client's immediate barriers to care and determines whether the client is appropriate for LTCS services. Clients who enroll in the program will then complete the required forms, including a barriers survey, which can be found as attachments to the protocol in Attachment A. Depending on circumstances, a client may verbally enroll in LTCS services with intake occurring at a later date. Within two weeks of enrollment the LTCS must also complete a comprehensive assessment with the client. The assessment can be found as an attachment to the protocol in Attachment A.
- **Service Plan Development and Implementation:** The results of the barriers survey and comprehensive assessment then form the basis of the client's service plan. The service plan outlines an individualized step-by-step approach for addressing the client's barriers to accessing and engaging in HIV medical care. The

Tip: *Texting was a successful way of communicating with clients.*



service plan is then implemented during the course of the client's enrollment in the LTCS program. Core service plan activities include assisting the client in scheduling and attending medical appointments, which often includes attending at least one medical appointment with the client, coordinating with the HIV care team, making necessary referrals, and providing emotional support.

- **Discharge:** Since the LTCS is focused on addressing barriers that have prevented the client from engaging in HIV medical care, the LTCS role ends once the client has achieved early retention. Early retention is defined as client attendance at a minimum of three HIV medical visits with a prescribing provider. The LTCS may work with the client for up to nine months to achieve early retention. While there is no minimum amount of time that the client must be enrolled in the program, clients would ideally remain enrolled until they have attended a minimum of three HIV medical visits. Prior to discharge, a transition plan must be developed and standards are outlined for ensuring a smooth transition to case management, if applicable.
- **Caseloads:** Due to the intensive nature of the program, the suggested caseload is no more than 15-20 clients per LTCS.

Tip: *Set expectations about program duration and discharge from the beginning to minimize client distress.*



REPLICATING THE LTCS PROGRAM

Described below are the agency infrastructure and implementation considerations for clinics and states in determining whether to adopt or adapt this program in their own jurisdiction. While some elements are considered to be core elements of the program (described previously), others may be more adaptable. Throughout this section and the Lessons Learned section we have noted where changes might be made.

Described below are agency types, existing systems of care that were leveraged in Wisconsin, staffing, training, supervision, oversight recommendations and cost.

AGENCY TYPES

There are ten full-time Linkage to Care Specialist positions located at eight agencies within Southeastern Wisconsin. Agencies vary in size and infrastructure and consist of AIDS Service Organizations (ASOs), hospital-associated HIV medical clinics, a health department, and federally qualified health centers (FQHC), most of which have on-site HIV medical care and one that does not. Each agency is described briefly below.

- **AIDS Network (AN):** An ASO located in Dane County, AN is a Ryan White Part B subcontractor that provides case management, housing assistance, oral health, and legal services to 400 clients annually. AN also offers HIV prevention and testing services. AN has six medical case managers, one benefits specialist and one LTCS.
- **AIDS Resource Center of Wisconsin (ARCW):** A statewide ASO headquartered in Milwaukee County, ARCW is a Ryan White Part C grantee and a subcontractor for Parts B and D. ARCW provides HIV medical, oral health, mental health and substance abuse services, pharmacy, food pantry, housing assistance, legal services, and medical case management to over 3,000 clients annually. ARCW also offers HIV prevention and testing services. The LTCS program was administered through the Milwaukee office, which has 16 medical case managers and three LTCS. An additional LTCS was employed and supervised by ARCW but was located at the Milwaukee Health Department.
- **Medical College of Wisconsin Division of Infectious Disease (MCW):** This hospital-associated medical clinic is a Ryan White Part B subcontractor and provides HIV medical, mental health and AODA services, pharmacy and medical case management to 600 clients annually. MCW has one medical case manager and one LTCS.
- **Milwaukee Health Department (MHD):** The MHD services the city of Milwaukee and is responsible for Partner Services for 450 HIV positive individuals annually, plus their named partners. The MHD also has an affiliated clinic that provides screening, diagnoses and treatment of sexually transmitted diseases, and conducts 3,000 HIV tests annually. The MHD has one on-site LTCS that is employed and



supervised by one of the other participating sites (ARCW previously and Outreach Community Health Centers currently).

- **Milwaukee Health Services, Inc. (MHSI):** MHSI is an FQHC that is a Ryan White Part C grantee and Part B subcontractor. MHSI provides HIV medical, mental health services, adherence counseling, and medical case management to 200 clients annually. In addition MHSI offers on-site and community-based HIV testing. MHSI has two nurse case managers, one medical case manager and one LTCS.
- **Outreach Community Health Centers (OCHC):** OCHC is an FQHC that offers non-HIV medical care and mental health and AODA services. The agency was previously a Ryan White Part B subcontractor for non-medical case management and outreach services. One LTCS is placed at OCHC. This LTCS recently began providing services 2-3 days per week at the Milwaukee Health Department.
- **Sixteenth Street Community Health Center (SSCHC):** SSCHC is an FQHC that is a Ryan White Part C grantee and Part B subcontractor. SSCHC provides HIV medical, mental health and AODA services, pharmacy, and medical case management to 200 clients annually. SSCHC also offers HIV prevention and testing services. SSCHC has four medical case managers and one LTCS.
- **UW Health HIV/AIDS Comprehensive Care Program (UW):** This hospital-associated medical clinic is a Part C grantee and a subcontractor for Parts B and D. The UW provides HIV medical, mental health and AODA services, pharmacy, and medical case management to 800 clients annually. The UW provides HIV medical care for approximately 150 HIV positive inmates within a Wisconsin Department of Corrections facility. UW has three medical case managers, one discharge planner for DOC patients, and one LTCS.

EXISTING SYSTEMS OF CARE

The success of Wisconsin's Linkage to Care Specialist program was heavily dependent on leveraging existing systems of HIV prevention and care in Wisconsin. A description of each prevention or care system and its role in the LTCS program is provided below.

State AIDS/HIV Program

Description: The Wisconsin AIDS/HIV Program is the lead agency in Wisconsin government responsible for coordinating the state's public health response to the AIDS/HIV epidemic. The existing Program Director has served in this role since 1983 and is responsible for directing a 24-person staff and managing a \$20 million annual budget. Housed within the AIDS/HIV Program are Surveillance; Prevention, including Counseling, Testing and Referral; Partner Services; Care, including the Ryan White and AIDS Drug Assistance (ADAP) Programs; and the hepatitis C program.



LTCS Program Role: The integration and co-location of the statewide HIV programs allowed for more timely communication and problem-solving across areas impacted by the new LTCS program. In addition, many of the AIDS/HIV Program staff involved in developing the LTCS program, problem-solving, and assisting grantees with implementation were not funded by this SPNS initiative and were therefore working in kind.

HIV Surveillance

Description: Confidential, name-associated reporting of confirmed HIV infection and AIDS is required by Wis. Stat. § 252.15 and has been in place since the early 1980s. Case reports are submitted to the Wisconsin AIDS/HIV Program from private physicians, hospitals, clinics, ambulatory care facilities, sexually transmitted disease clinics, the Wisconsin correctional system, family planning clinics, perinatal clinics, Indian health clinics, blood and plasma centers, military entrance processing stations, and laboratories performing HIV testing. AIDS and HIV cases are reported directly to the state epidemiologist rather than local health departments and are entered into the CDC-mandated Enhanced HIV AIDS Reporting System (eHARS).

Laboratory-based reporting is also required by law. Laboratories performing confidential, name-associated HIV confirmatory testing report the name of the subject of all positive test results and the name of the physician who ordered the test to the AIDS/HIV Program. In addition, laboratories are required to report all CD4 and viral load test results, regardless of the result.

LTCS Program Role: Timely reporting of new HIV cases to Surveillance staff and access to high quality case information has contributed to the overall efficiency of the LTCS. First, cases entered into eHARS are passed to the Partner Services (PS) coordinator for assignment to a local worker. As PS staff serve as a key referral source to the LTCS program, timely case reporting, case assignment to PS, and PS outreach increase the likelihood that a successful referral to the LTCS program can be made. Second, many of the LTCS contact surveillance staff to check the status of individuals who are out of care. LTCS can be more targeted in their outreach efforts if they are able to exclude out-of-care cases who are found to be deceased, living out of state, or are receiving care elsewhere. This is especially important as Wisconsin is not a CAREWare state and therefore there is no real-time care data accessible to staff from multiple agencies for shared clients. Finally, surveillance data could be used to drive Data-to-Care efforts. While not currently happening in Wisconsin, cases newly reported to the Surveillance program who are not linked to care or who are out of care could be referred directly to the LTCS, depending on local confidentiality laws and practices.

Partner Services

Description: HIV Partner Services (PS) workers assist people newly reported with HIV infection in notifying their sexual and/or needle sharing partners of a possible exposure to HIV. Wisconsin state law authorizes the Wisconsin Division of Public Health (DPH) and local health departments (LHD) to conduct surveillance, follow-up efforts, and other public



health activities in order to manage and control communicable diseases. The DPH has officially designated the LHDs to assist in conducting disease control activities, including HIV PS. The PS coordinator, located within the AIDS/HIV Program, coordinates statewide PS activities, including assigning all newly reported HIV cases to the local PS provider. The provision of PS is regionalized in areas of Wisconsin with fewer HIV cases such that staff from a single county will provide partner services on behalf of multiple counties in the region.

LTCS Program Role: As PS providers have the opportunity to interact with all individuals newly diagnosed or reported with HIV infection, they serve as a key referral source into the LTCS program. Embedding an LTCS within the Health Department that conducts PS, such as in the Milwaukee Health Department, allows for a more seamless referral and transition to LTCS services. In some cases, the LTCS may also facilitate a successful interview with the PS provider.

Counseling, Testing and Referral Program

Description: The Counseling, Testing and Referral (CTR) Program is a statewide network of publicly-funded HIV counseling, testing, and referral services staffed by trained counselors in local agencies. Clients receive risk assessment, personalized risk reduction counseling, free or low-cost testing, and referral for medical and supportive services if found to be HIV positive. The program has been instrumental in assisting individuals with HIV in accessing medical treatment, social support, and PS services. It has also been an important HIV prevention strategy. Every client who is tested is also counseled to reduce their risk of acquiring or transmitting the disease. The CTR program currently consists of 33 agencies providing counseling and testing services in 49 locations throughout the state.

LTCS Program Role: Like PS, the CTR Program has been instrumental to the success of the LTCS program. The CTR program is coordinated by the AIDS/HIV Program and therefore the CTR agencies have been updated on the progress of the LTCS program implementation since the beginning. CTR sites have served as the primary referral source for new diagnoses into the program, especially as CTR staff conduct HIV testing often for the low resource, high-risk individuals that the LTCS program targets. In addition, many CTR sites have an on-site LTCS, which makes for a smooth referral and reduces the risk that the client will be lost before a linkage can be made. Some of the LTCS even conduct HIV testing and can therefore transition from counselor and tester, to LTCS. Finally, many of the CTR sites have implemented the fourth generation testing algorithm and can therefore identify acute HIV infections. These cases are almost always referred directly to an LTCS to ensure early linkage to care and prompt connection to PS.

Case Management System

Description: Wisconsin spends approximately \$1.7 million annually in Ryan White Part B and state General Purpose Revenue to fund a long-standing case management system. Wisconsin's case managers are focused on ensuring adherence to HIV medical care and making referrals for necessary services. In some settings there are both clinical and non-



clinical case managers, or nurse case managers and social work case managers. Non-clinical case managers may be responsible for 60-70 individuals while also providing brief services to lower acuity clients. Case managers at the larger hospital-based systems may have a smaller caseload of varying size but are also available to provider brief services to all patients within the clinic. All locations with a Linkage to Care Specialist also offer case management services with the exception of the Milwaukee Health Department and Outreach Community Health Centers.

LTCS Program Role: The case management protocol and training program served as the basis for the LTCS program, as the two types of providers offer similar types of services. In addition, case managers serve as referral sources for clients who need a more proactive and intensive service than traditional case management can provide. Finally, case managers begin to develop relationships with LTCS clients as part of transition planning.

Department of Corrections

Description: The Wisconsin Department of Corrections (DOC) houses approximately 150 HIV positive inmates annually. The Wisconsin DPH has an excellent working relationship with the DOC and has joint quarterly meetings to discuss HIV and hepatitis C projects and issues.

LTCS Program Role: All HIV care for DOC inmates is provided by a central facility, the UW Health HIV/AIDS Comprehensive Care Program (UW). Also housed at the UW is a social worker who oversees discharge planning for inmates within the six months prior to their release date. Discharge planning involves applying for ADAP and making appointments for medical care and case management. The inmate social worker is a critical referral source for the post-incarcerated clients of the LTCS program.

CONFIDENTIALITY

Confidentiality related to HIV is governed by Wis. Stat. § 252.15 (3)(m). These laws allow for disclosure of an individual's HIV status without consent by the individual, for HIV and AIDS reporting, the provision of Partner Services, and other well-defined circumstances. Although not governed by the Health Insurance Portability and Accountability Act (HIPAA), the AIDS/HIV Program has established written guidance in compliance with HIPAA and state confidentiality laws surrounding health related information. HIV care providers and agencies are required to ensure that their practice conforms to these policies and procedures. In addition, the LTCS protocol (Attachment A) specifies necessary procedures to be taken as part of the LTCS service to protect client confidentiality.

The disclosure laws referenced above limit the LTCS to serving out of care clients within their own agency as the individual's HIV status is already known and therefore consent is not required. In addition, as Wisconsin does not have a networked CAREWare system, there is no data sharing across sites for shared or transferred clients. This lack of data sharing makes it difficult for LTCS who are trying to locate clients who have fallen out of care.



PRE-IMPLEMENTATION ACTIVITIES

Agency Buy-In

In general, agency buy-in to implement the Linkage to Care Specialist program was almost immediate. Existing partners were identified as the intervention sites and agency leadership recognized that the new position would improve agency capacity to address linkage, retention, and viral suppression issues, especially among higher acuity clients. In addition, agencies were interested in addressing many of the social determinants of health that impact individuals' adherence to care. However, some agencies experienced a more difficult time implementing the new program, primarily due to role confusion and concern about service duplication and overlap. Factors for successful agency buy-in and support included:

- Agency staff attendance at the Learning Sessions (described below),
- Connection of the program to established medical goals and benchmarks,
- Structural capacity to provide space and supervision to a new staff person,
- Internal staff meetings to explain and discuss the LTCS role in relation to existing roles,
- Development of internal procedures to avoid confusion (i.e., developing a formal internal process for LTCS referral and triage), and
- Continued feedback to leadership with interim results to ensure that support for the program continued.

Learning Sessions

Additional buy-in was gained through statewide Learning Sessions required as part of the Collaborative Learning Model. These one or two-day meetings brought together HIV prevention and care providers, local health departments, the Department of Corrections, consumers, and other interested parties to discuss the development and implementation of the LTCS program.

Individual Provider Meetings

Through both Learning Sessions and individual provider meetings (e.g., Partner Services), key referral sources were trained on the LTCS program, eligible clients, and how to make referrals.

Agency Site Visits

LTCS site visits to clinics, HIV testing sites and community-based organizations were coordinated by the AIDS/HIV Program. These site visits allowed the LTCS to become more familiar with key HIV care providers in their area, to meet with clinic and agency staff, and to promote the LTCS program. These site visits were also an important component of the LTCS training plan.



LTCS Brochure Development

During the pilot phase of the program, the LTCS wanted to be able to provide a consistent and comprehensive overview of the program to potential clients. Therefore the LTCS worked collaboratively to develop a brochure to hand to clients or to leave with potential referral sources. A sample brochure is in Attachment B.

Agency Criteria for Identifying Individuals for Enrollment

As described previously, there were no set criteria for eligibility for the Linkage to Care Specialist program other than to be one of the five eligible client types. Agencies with an on-site LTCS identified appropriate clients as follows:

- Most agencies use their electronic medical record (EMR) to identify clients who have not had a medical visit for four-to-six months. Clients without a scheduled visit are contacted and if no follow-up appointments are made, the client is offered the Linkage to Care Specialist program. Considerations are made for viral load suppression as well as past appointments and adherence. In addition, most agencies are tracking missed appointments and making referrals for clients with two or more missed visits.
- Clients may be referred directly to a LTCS by their medical provider if there are known barriers to care (e.g., substance abuse, chronic homelessness, language or cultural barriers).
- Individuals with barriers to care who are unsuccessful in the existing case management system are referred to the Linkage to Care Specialist program.
- Some agency's LTCS also conduct HIV testing, and are therefore able to evaluate newly diagnosed individuals for the program at the time of diagnosis.
- On site pharmacies also make referrals to the LTCS program if clients did not pick up medication refills.

STAFFING

Described below are the LTCS staffing levels in Wisconsin, the position requirements, a description of roles and responsibilities, and an outline of the differences between the LTCS program and Wisconsin's existing case management program.

Staffing Levels

The number of LTCS per agency varied as described previously. The number of LTCS may vary depending on the number of new diagnoses and prevalent cases in an area, the number of clinic patients, the presence of an existing case management infrastructure, and the number of high need clients. The agency infrastructure and staffing levels should support LTCS caseloads of 15-20 clients.



Position Requirements

Linkage to Care Specialists in Wisconsin are non-medical professionals who receive specific training on the basics of HIV transmission, disease progression and treatment, principles of case management, motivational interviewing, and professional ethics. LTCS backgrounds ranged from Bachelor's degrees in non-HIV related fields to Licensed Clinical Social Workers. In addition, some had worked previously as case managers in Wisconsin and some had HIV testing experience. While all LTCS have been successful, those with prior case management experience had the most knowledge about the Wisconsin system of care upon starting the position and were therefore able to come up to speed most quickly.

Grantee agencies were responsible for their own position recruitment and hiring. However, candidate recommendations were provided to the agencies in the form of a performance profile (Attachment C). Some requirements may not apply to all settings or client types.

Client Quote: *"[My LTCS gave me] information about setting up appointments with the hospital or maybe even with a case manager. That made me feel, like, more confident, like I can get through this a little bit more."*

Roles and Responsibilities

The primary roles of the Linkage to Care Specialist are to:

- Identify and address barriers that prevent, or have prevented, the client from engaging in HIV medical care, and
- Prepare the client to maintain engagement in HIV medical care after discharge from the LTCS program.

The responsibilities of the LTCS can be found throughout the protocol (Attachment A) and the performance profile (Attachment C). However, key responsibilities are listed below.

- Identify out-of-care individuals within a clinical setting.
- Triage referred cases to identify those appropriate for the LTCS program.
- Complete intake and other required screenings to identify potential barriers to care and treatment preferences.
- Develop and implement a client-specific service plan.
- Ensure linkage to the initial clinical care appointment within three months of diagnosis or within three months of service initiation.
- Facilitate, accompany, and/or transport clients to clinical appointments at the clinical location or with the provider of their choice.
- Conduct in-depth harm reduction screening and counseling as needed.
- Provide HIV disease and treatment education.
- Maintain proactive, frequent contact with the client and their care team.
- Attend quarterly Linkage to Care Specialist training sessions hosted by the Wisconsin AIDS/HIV Program.



Differentiation from Case Management

Initially there was significant confusion among agency staff and HIV service providers regarding the difference between the new Linkage to Care Specialists and the existing case managers. The two services are similar primarily in the processes used to serve clients, including conducting assessments, developing individualized service plans, and making referrals for services. However, the LTCS program is different in that the LTCS:

- Focuses primarily on addressing client barriers that prevent linkage to or engagement in HIV medical care. The LTCS refers their clients to existing case managers for assistance with needs that do not affect medical adherence. This is in contrast to case management, in which the case manager assists their clients with all needs.
- Has a smaller caseload of 15-20 compared to case management caseloads of 60 or more, which allows:
 - More proactivity in contacting clients,
 - The ability to travel to meet clients in the field or at home, attend appointments with clients (medical care, dental, and other specialty medical care), and coordinate care across facilities and providers, and
 - The ability to provide a more intensive service level characterized by a significant amount of one-on-one time and contacts multiple times per day or week.
- Uses motivational interviewing to serve clients (note that during the implementation of the LTCS program, motivational interviewing training was offered to case managers as well).
- Has a work cell phone, which allows for more availability to clients and allows LTCS to text with clients.
- Serves clients for a maximum of nine months, whereas there is no time limit on case management services.

Client Quote: *“[My LTCS] calls me most of the time just to see how I’m doing and is everything all right, or what do I need, or did I go to my doctor’s appointment.”*

TRAINING

Protocol

The LTCS protocol specifies that each agency is responsible for providing the LTCS and their supervisors with job-related training that commences within 15 working days of hire. Agency training includes reviewing agency policies, procedures and protocols and providing training on internal data management systems.



Training Checklist

The AIDS/HIV Program required all new LTCS and their supervisors to complete a checklist of required trainings and training activities (Attachment D). The checklist outlined formal trainings and meetings as well as informal training activities, such as job shadowing of test counselors and case managers, meeting with various provider types (e.g., Partner Services), attending clinical site visits, reading key articles, and using existing client documentation to practice assessment skills.

Site Visits

LTCS site visits to clinics, HIV testing sites and community-based organizations were coordinated by the AIDS/HIV Program. These site visits allowed the LTCS to become more familiar with key HIV care providers in their area, to meet with clinic and agency staff, and to promote the Linkage to Care Program.

Quarterly Meetings

Quarterly face-to-face meetings have been a consistent training mechanism during the development and implementation of the LTCS program. These meetings provide a forum for case presentations, trainings through guest speakers and webinars, and training on data collection and documentation. Training topics provided by guest speakers include: communicating with clinical staff, ethics and case management, prevention with positives, securing health benefits, mental health and AODA screening, active case finding for field workers, health literacy, culturally competent practice, treatment adherence/medication, and local housing assistance programs.

Formal Trainings

In addition to on-site agency training and AIDS/HIV Program-sponsored speakers, LTCS were required to take formal training coordinated by the Wisconsin HIV/AIDS Training System⁷. The Wisconsin HIV/AIDS Training System organizes and coordinates training for Ryan White Part B and CDC Prevention subcontractors, program managers, local public health providers, and others who provide HIV care and prevention services. Some trainings are required for Program grantees and others are optional.

LTCS-required trainings consisted of HIV Basics, HIV Counseling Skills, and New Case Manager Orientation. SBIRT training (Screening, Brief Intervention and Referral to Treatment) was not required but all LTCS completed the training. Training descriptions of both required and optional trainings can be found in Attachment E. In addition, LTCS are required to take ten hours of continuing education annually. Many LTCS use the optional trainings offered through the Training System to satisfy their continuing education requirements.

⁷ The Wisconsin HIV/AIDS Training System can be accessed at <http://wihiv.wisc.edu/trainingsystem/>.



SUPERVISION

All LTCS are required to have an onsite supervisor who has a background and extensive experience with HIV service delivery systems. Supervisors are responsible for initial and ongoing training of LTCS as well as completion of annual performance reviews. New LTCS should be monitored by their supervisor for satisfactory completion of linkage to care specific tasks such as assessments, service plan completion and client counseling sessions. These activities should be monitored in person at least once before the LTCS is approved to provide services independently. Supervisors should also keep a training record that includes specific training topics, completion dates, and the employee's initials next to each training topic.

At a minimum, supervisors should meet with the LTCS to discuss cases:

- After the initial creation of the LTCS service plan,
- After a client has been a program participant for six months,
- Prior to a client being discharged from the LTCS, and
- When necessary (recommended monthly) to discuss such topics as client caseload progress, program issues, training needs, monitoring and evaluation forms, or assistance with referrals.

MONITORING

Since the LTCS program implementation was coordinated at the state-level, the AIDS/HIV Program conducted the majority of the monitoring activities, while agency staff conducted the supervisory activities listed above. State-level monitoring consisted of the following activities:

Site Visits

Annual site visits, or more frequent if necessary, are conducted with each agency that employed an LTCS. During the site visit AIDS/HIV Program staff discuss successes and challenges privately with the LTCS, the supervisor, and then both staff together. Private meetings were discontinued in future site visits once the program was fully implemented. These site visits also provide an opportunity for state staff to monitor fidelity to the LTCS protocol.

Chart Audits

During site visits AIDS/HIV Program staff review a sample of LTCS client charts. The purpose of the chart audit is to ensure that LTCS are following the protocol, providing high quality services to clients, and correctly documenting encounters. Chart audits are conducted as the first part of a site visit so that the results can be discussed with agency staff during the latter part of the visit.



Data Collection and Evaluation

LTCS implementation was also evaluated through daily encounter data collected as part of the SPNS cross-site evaluation, and client outcome data. In order to evaluate the amount of time LTCS were spending with clients, the places where services were occurring, the modes of communication, and the content of communication, LTCS documented each client encounter on the Daily Encounter form. This form can be found as an attachment to the protocol in Attachment A. While this intensive level of data collection may not be reasonable long-term, it is useful for evaluating the implementation of a Linkage to Care Specialist program. Daily encounter data were aggregated and presented at each quarterly meeting as a means of commending the LTCS on their work and, if necessary, providing additional training and guidance on service provision.

In addition to the process measures described above, client outcomes were measured using data from the HIV Surveillance program. Clients enrolled in the LTCS program were evaluated for linkage to care (if newly diagnosed), retention to care, and viral suppression. These outcomes were measured both while the client was enrolled and after discharge. While the preliminary results are promising, the final cross-site and local evaluation results will not be available until spring 2016.

COST

As part of the SPNS Systems Linkages initiative, Wisconsin received \$1 million per year over the four-year grant period. For the LTCS initiative, the funds were used to cover LTCS salaries, a small portion of some LTCS supervisor salaries and evaluation staff salary. Most of the staff working on program development and supervision were paid by other funding sources and were therefore in kind on this project.

Each agency with an LTCS was given \$63,140 per LTCS from the SPNS funding to cover salary, benefits and supplies, and two agencies were paid for evaluation activities. Two agencies received additional dollars through Part B Supplemental funding to cover higher fringe rates at those agencies. A breakdown of annual funding by agency is listed below in Table 1. In the future, Wisconsin plans to use Ryan White Part B funding to continue the LTCS program.



Table 1. LTCS funding by agency

Agency Name	Funding Amount	Funded Activities
AIDS Network	\$63,140	LTCS (1)
AIDS Resource Center of Wisconsin	\$252,560	LTCS (4)
Center for AIDS Intervention Research	\$52,000	local evaluation, cross-site evaluation support
Medical College of Wisconsin Division of Infectious Disease	\$66,958	LTCS (1)
Milwaukee Health Services, Inc.	\$63,140	LTCS (1)
Outreach Community Health Centers	\$63,140	LTCS (1)
Sixteenth Street Community Health Center	\$63,140	LTCS (1)
University of Wisconsin School of Medicine and Public Health	\$167,317	LTCS (1), local evaluation, cross-site evaluation support



LESSONS LEARNED

EVOLUTION OF THE LTCS PROGRAM

Starting in April 2012 the LTCS protocol was drafted, tested, and fine-tuned. After a series of PDSA cycles and formal and informal feedback, the protocol was finalized in September 2014. Core service elements that were modified from the original to the final protocol consisted of the duration of the service, eligible client types, LTCS focus areas, and transition planning. The original protocol specifications, the LTCS experiences, and the resulting protocol modifications are summarized in Table 2.

Also described below are successes and challenges experienced in Wisconsin that other jurisdictions may experience if implementing a similar program. Now that the protocol has been implemented for over two years and the LTCS have had the opportunity to provide feedback both informally and during formal focus groups, there are also changes that Wisconsin would recommend for the future. Those recommendations are also described below.

Medical Provider Quote: *“I can’t imagine now trying to function effectively in clinic without [our LTCS], or someone in [her] role. I have had numerous cases where [our LTCS] was instrumental in getting the patient in to clinic with me, many more where she was instrumental in keeping the patient engaged in care, and also a couple more where I asked her for help with someone new who needed help and resources to get in and stay in the system. I can’t imagine how any of these people would have been successfully engaged in care without the intensive efforts of [our LTCS]. I suppose they would have been lost and still be out there somewhere without care instead of being engaged and on treatment. Many of these patients had their initial contact with the system as hospital inpatients (admitted through the ER) and are now instead being kept out of the hospital and in outpatient care which is cheaper and more effective.”*



Table 2. Linkage to care specialist protocol modifications

Original Protocol	LTCS Experience	Protocol Change
LTCS work intensively with clients for 12-18 months	<ul style="list-style-type: none"> • Timeframe too closely mirrored existing case management service. • LTCS were reporting full caseloads and openings for new clients were not readily available. • Clients were reluctant to be discharged after working with their LTCS for an extended period of time. • Some clients, especially those newly diagnosed, showed signs of readiness for discharge within six months. 	LTCS work with clients for a maximum of nine months and at a minimum until early retention (three HIV medical appointments) is achieved.
LTCS work with four client types: newly diagnosed, new to care, out of care and post-incarcerated	LTCS were accepting clients onto their caseload who did not meet any of the definitions but who were high-need clients.	“At Risk” was added to the list of eligible client types.
LTCS were assigned a specific focus area that determined which type of client they worked with	Referrals were not evenly divided between LTCS.	LTCS may work with any of the eligible client types.
LTCS provided a broad scope of services that expanded beyond addressing client barriers to engagement in HIV medical care	<ul style="list-style-type: none"> • LTCS were reporting full caseloads while only serving five to seven clients. • LTCS were isolated from other members of the care team. • LTCS and case managers were voicing concerns regarding service duplication and 	<ul style="list-style-type: none"> • Establishes LTCS primary function as addressing client barriers that have prevented linkage to and engagement in HIV medical care. • Required use of LTCS client survey at intake and discharge to identify client



	<p>role confusion.</p>	<p>barriers to care.</p> <ul style="list-style-type: none"> • Allows LTCS to facilitate referrals to case managers to address client issues not directly resulting in barriers to medical care.
<p>LTCS complete “close-out” assessment close to the time of discharge to determine if client will transition to case management</p>	<ul style="list-style-type: none"> • LTCS were reporting that clients were anxious about transition because they were not familiar with their new case manager. • LTCS were worried that clients would disengage from medical care after transitioning to case management. 	<ul style="list-style-type: none"> • Requires LTCS to discuss transition to case management or self-management with client at enrollment and frame transition as successful completion of LTCS program. • Requires target transition date and discharge service level be documented on LTCS service plan. • Requires two case conferences with post-LTCS case manager prior to discharge to develop and finalize LTCS transition plan. • Requires LTCS to follow up with client/case manager three and six months post discharge to evaluate the client’s level of engagement in care.



SUCSESSES

The following successes were noted by the LTCS, their supervisors, state staff and/or clients.

- The presence of a LTCS provides additional capacity at high volume clinics, especially for meeting clients out of the office or in an inpatient setting.
- Small caseloads also allow the LTCS more flexibility in scheduling so that they are available for meeting newly diagnosed individuals in the field at the time of diagnosis.
- Small caseloads have allowed the LTCS to more proactively address client barriers and acute crises, to have a more intensive level of contact with clients, and to meet clients in the field. Meeting clients in the field allows for home visits, meeting clients in settings that are more comfortable to the client, attending appointments with the client, and for providing transportation to the client if needed.
- The relationship clients have with their LTCS is an important factor in helping them to feel supported and motivated.⁸
- Texting was recognized as a critical mode for successfully reaching and communicating with clients.
- Having an LTCS located at a health department was helpful for offering services to newly diagnosed individuals, including both those who tested positive at the health department as well as those being contacted for Partner Services.
- The overall concept of using a barriers survey to more explicitly identify potential barriers to care was well-received by the LTCS and their respective agencies. The survey has been incorporated into some clinical practices and will continue to be used by many agencies in some form. However, suggestions were made to incorporate the survey into the existing assessment or incorporate the survey questions conversationally rather than administering the tool as a formal survey.
- The LTCS are developing expertise in serving clients with barriers to medical care and are therefore gaining a reputation among providers as the “go-to” person for linkage and retention issues.

Client Quote: *“When I met her she kind of motivated me and made me realize, you know, that it’s nothing bad. She made me feel like I was a human again.”*

⁸ Broaddus MR, et al. She makes me feel that I’m not alone: Linkage to Care Specialists provide social support to people living with HIV. *AIDS Care*. 2015;April 9:1-4.



- Evaluation was an important component of this initiative, both locally and across the six states. Preliminary outcomes for linkage to care, retention to care and viral load suppression for Linkage to Care clients, compared to controls, are promising.
- Since the development and implementation of the LTCS program, additional services are being evaluated for their impact on linkage to care, retention in care, and viral load suppression. One example is that Wisconsin's case management acuity scale was revised to more heavily weight indicators of poor adherence to care.
- Some agencies are adapting pieces of the Linkage to Care Specialist program to address retention among other disease populations, such as diabetes and asthma.

CHALLENGES

The following challenges were experienced during the implementation of the LTCS program. Some challenges have been resolved while others are ongoing.

- Initially there was significant role confusion about the difference between the LTCS and existing case managers. There has been improvement over time with more awareness of the Linkage to Care Specialist program, provider education, and further differentiation of roles. However, there is still some concern about service duplication and role confusion for shared clients.
- Initially LTCS were providing a lot of transportation to clients for various appointments. While this was helpful for clients, it created a dependent relationship and the LTCS program was getting a reputation as a transportation service. The LTCS still provide transportation as needed, but strive to teach the clients how to use independently use existing transportation systems.
- Partner Services staff in Wisconsin have the responsibility to both elicit partners and link individuals to HIV medical care. Initially PS staff were concerned about their ability to successfully interview clients if they were already linked to care by an LTCS. However, in many cases LTCS were able to facilitate a successful interview by PS staff.
- When the program was first implemented there was hesitation among some medical providers about having the LTCS in the exam room with the patient, especially if the LTCS was from a different agency, even if the patient consented. This issue has been resolved as the medical providers have become more familiar with the program and as the LTCS have become more knowledgeable about clinic operations and HIV medical care.
- Existing confidentiality laws and the fact that Wisconsin does not have a networked CAREWare system means there is no data sharing across sites for shared or transferred clients. This lack of data sharing makes it more difficult for LTCS who



are trying to locate clients who have fallen out of care or who are managing clients outside of their own agency.

- Clients are resistant to transition from the LTCS program to self-management or case management given the intensive nature of the LTCS service. Despite transition planning and setting client expectations at the time of enrollment, many clients continue to contact their LTCS even after being discharged from the service.
- Many of the LTCS clients will continue to need intensive services even after discharge from the LTCS program. High caseloads within the existing case management system limit the proactivity and amount of time that can be spent serving high acuity clients.
- While texting has been recognized as a key mode of communication with clients, not all case managers have the ability to text, which may present communication difficulties for the client after being discharged from the LTCS program.
- Referring agencies were given broad criteria for identifying and referring individuals for the LTCS service. In some cases existing guidelines were not followed (e.g., new diagnoses were sometimes referred regardless of the presence of other complicating factors). Therefore the LTCS were in a position to triage appropriate clients. While this may seem like a task best completed by the referring sites, the LTCS felt that they began to develop a relationship with individuals during the triage process, which created a more seamless experience for those clients who were appropriate for the LTCS program. For some sites an acuity scale or other concrete criteria might be preferred to assist in identifying appropriate clients for referral to LTCS services.
- Some agencies have had difficulty maintaining their LTCS. Several of the specialists left to take other positions within the same agency, while others left to pursue other opportunities. It is possible that retention was an issue partially due to the uncertainty of the future of the LTCS program.

RECOMMENDATIONS FOR IMPLEMENTATION

Based on the successes and challenges described above, and other lessons learned, Wisconsin makes the following recommendations for modification or has identified key points to consider:

- **Determine whether LTCS will take a generalist or specialist approach:** LTCS in Wisconsin are still assisting their clients with all needs, rather than referring out non-HIV care related needs to case managers as the protocol specifies. While assisting clients with *all* of their needs may be more seamless for the client, it may also limit an LTCS's caseload.



- **Balance LTCS caseloads to allow for pre-enrollment activities for incarcerated individuals:** The LTCS protocol does not describe the pre-release activities that likely contribute to the success of the LTCS program for PLWHA who are being released from a correctional facility. For incarcerated individuals, the LTCS program is primarily a post-release program and therefore the protocol and data collection begin once the individual is released. However, the LTCS spend a considerable amount of time developing a relationship with the individuals prior to release through letters or visitation, securing post-release housing and benefits, and collaborating in many cases with the on-site DOC social worker and the discharge planner.

Client Quote: “[I] needed somebody that could take care of, you know, the medical part. Like when I got out, I didn’t have my medical insurance or anything; so the Linkage to Care Specialist, you know, they’re dealing with the doctors, they’re making sure that I get my medications...so initially that was what the central focus was for my getting the Linkage to Care Specialist. “

- **Incorporate client locator form into existing systems:** A client locator form was developed for LTCS to collect alternative phone numbers and contacts for their clients. However, the LTCS felt this form was redundant to the information captured in existing systems, and therefore this form will be discontinued in Wisconsin.
- **Ensure LTCS have smart phones or tablets for field use:** LTCS were originally provided laptops for use in the field. However, LTCS stated that smart phones or tablets would be easier and less formal for conducting internet searches and collecting data while assisting clients in the field.
- **Identify criteria for eligible clients:** Develop and implement an acuity scale, or provide additional training, to assist referral sources in identifying eligible clients for the LTCS program.
- **Consider the duration of the program:** The duration of the program may vary based on client need. Nine months is long enough that a close relationship develops making transition out of the program difficult. In addition some clients, especially those who are newly diagnosed, may need less time with the specialist.

Tip: The comprehensive assessment can be completed over the course of multiple interactions with the client and the results may reside across various information systems. This prevents multiple providers from asking clients the same questions and makes the assessment process less overwhelming for the client.

- **Ensure that there is adequate LTCS supervision:** Supervision has been identified by the LTCS as a key factor for avoiding burnout. The supervisors played a critical role in providing guidance for difficult clients and for ensuring that caseloads were of appropriate size and balance.



- **Consider when to involve the case manager to whom the client will be discharged:** While the protocol specifies the timeline for client introduction to case management, transition out of the LTCS program may be easier by earlier and more frequent interactions with the case manager to whom the client will be discharged. One agency embedded three, six and nine month milestones to discuss transition planning with clients.
- **Consider additional training topics:** LTCS have stated that the following trainings would be helpful for better assisting clients: motivational interviewing via text messaging, boundaries, introduction to social work, medication and adherence, and more frequent benefits training.
- **Consider alternative discharge criteria:** The current LTCS protocol uses time or attendance of at least three HIV medical visits as the criteria for completion of the program. The LTCS suggested a reduction in acuity or viral load suppression as possible alternative discharge criteria.
- **Remove or enforce the post-discharge follow-up contacts:** The current LTCS protocol specifies following up with discharged clients three and six months after discharge from the LTCS program. These follow-up contacts are not formally occurring and therefore could be removed from the protocol.
- **Conduct routine education about the LTCS program:** Conduct routine promotion of, and education about, the LTCS program among referral sources, especially among testing sites, hospitals, clinics, and non-traditional providers.
- **Involve front-line staff while planning for implementation:** Involve front line staff in the implementation planning stage to avoid role confusion and to ensure that staff at all levels receive the same information.

SUSTAINABILITY

Pending the final results of the local evaluation in 2016, Wisconsin plans to continue the Linkage to Care Specialist program as part of the broader medical case management program. It is likely the program will change somewhat based on the recommendations described above. Funds from Ryan White Part B, the Minority AIDS Initiative, and local clinic revenue will be used to continue supporting the existing LTCS.



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For more information about the Linkage to Care Specialist program, please contact Mari Ruetten (mari.ruetten@dhs.wisconsin.gov) with the Wisconsin AIDS/HIV Program.

Table 3. Key staff involved in the LTCS program implementation

<p><u>Program Development and Implementation</u> Alison Meier Casey Schumann* Claudia Habib Franela Ngaboh-Smart James Vergeront* Leslie Anderson* Mari Ruetten* Michael McFadden</p> <p><u>Local Evaluation</u> Mary Peng Michelle Broaddus* Ryan Westergaard Timothy Hess</p> <p><u>Linkage to Care Specialists</u> Amy Zarr Angelica Picado Brianna Johnson Diane Thompson Emma Nelson Erin Robbins Hannah Fogarty Katie Andaloro Kelly Dresser Mari Carmen Saavedra Maria Selig Meera MacDonald Norah Boynton</p>	<p>Sarah Deitz Tracey Hagedorn Tracey Jackson Yvette Buckhaulter</p> <p><u>Linkage to Care Specialist Supervisors</u> Ericka Sinclair Joanna Woodbury Jose Salazar Jennifer Ward Jennifer Alfredson Kimberly Sherard Laura Johnson* Megan Corey Rachel Luzbetak Yvonne Bell-Gooden</p> <p><u>Steering Committee</u> Andrew Petroll Laura Johnson Kathleen Krchnavek Mandy Kastner Mary Jo Hussey Tony Somlai</p> <p><u>HRAS Project Officer</u> Pamela Belton*</p> <p><u>Education and Technical Assistance Center Coach</u> Jane Fox*</p>
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**Also participated in the Steering Committee*



ATTACHMENTS



LTCS MANUAL ATTACHMENT A: LTCS PROTOCOL

HIV Linkage to Care Specialist (LTCS): Practice Standards and Protocol

WISCONSIN AIDS/HIV PROGRAM
Bureau of Communicable Diseases
Division of Public Health
Wisconsin Department of Health Services



Updated: September 25, 2014

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APPENDIX F: Linkage to Care Daily Encounter Form

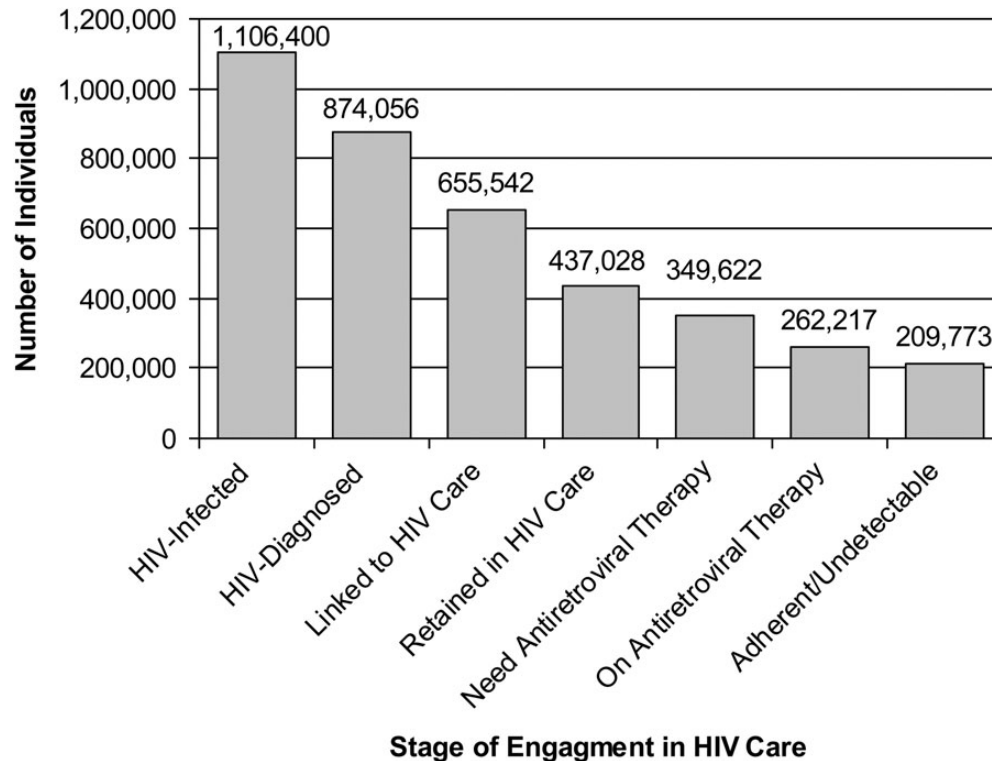
APPENDIX G: Linkage to Care Transition Plan

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INTRODUCTION

In a 2011 *Clinical Infectious Diseases* article by Edward Gardner et al, it was estimated that only 19% of HIV positive individuals living in the United States have an undetectable viral load. This is the result of individuals dropping out care at some point between initial diagnosis and achieving viral suppression. Figure 1 provides a visual representation of the different levels of engagement in HIV care, referred to as the HIV care continuum. It is estimated that of the 1.1 million individuals diagnosed with HIV, only 0.2 million individuals are adherent to treatment and have an undetectable viral load.

Figure 1: The spectrum of engagement in HIV care.



The data presented in the Gardner article reinforce the need to promote the goals of the National HIV/AIDS Strategy, specifically the goal to increase access to HIV care and optimize health outcomes for individuals living with HIV. As part of the effort to increase engagement in HIV care, improve health outcomes, and ultimately reduce disease transmission, the Health Resources and Services Administration (HRSA) is funding a four-year demonstration grant to support the design of innovative models that will assist HIV positive individuals to link to and stay engaged in HIV medical care.

In September 2011, the Wisconsin AIDS/HIV Program was selected by HRSA to be one of six states to participate in the project. The first two years of the initiative are focused on developing and testing linkage and retention strategies that will be implemented and evaluated in years three and four of the initiative. At the end of the project, program evaluators will identify which strategies were most successful. These strategies will then be:

- disseminated nationally by HRSA;
- incorporated locally into contracts for Ryan White and Life Care Services providers; and
- shared state-wide with all HIV service providers as best practices to improve clinical outcomes for clients.

A key strategy of Wisconsin's plan is the development of a new position known as a Linkage to Care Specialist (LTCS). The LTCS serves as a patient navigator, providing short-term, intensive case management services aimed at assisting clients' in identifying and overcoming barriers to accessing and maintaining engagement in HIV medical care. Through this process, the LTCS provides the client with the knowledge and skills necessary to actively participate in their healthcare and maintain engagement in care and adherence to treatment after discharge from linkage to care (LTC) services.

The following definitions have been established for the purposes of this initiative:

- **Linkage:** Client attendance at the first scheduled routine HIV medical visit with a prescribing provider after being diagnosed with HIV infection.
- **Re-linkage:** Client attendance at the first scheduled routine HIV medical with a prescribing provider post-incarceration or after being out of HIV care for more than six months.
- **Early Retention:** Client attendance to at least three HIV medical visits with a prescribing provider within the first nine months of being linked/re-linked to care.

The LTCS works with five client populations:

1. **Newly Diagnosed:** clients first diagnosed with HIV infection during the previous 90 days.
2. **New to Care:** clients previously diagnosed (more than 90 days ago) with HIV infection but not previously linked to HIV medical care.
3. **Out of Care:** clients who have not attended an HIV medical visit during the previous six months.
4. **Post-incarceration:** clients previously diagnosed with HIV infection who are referred by and recently released from a Wisconsin Department of Corrections (DOC) institution.
5. **At-Risk:** clients who meet one or both of the following criteria:
 - a. Have missed two or more consecutive HIV medical appointments.
 - b. Have a detectable viral load while on HIV treatment.

The LTCS identifies barriers that have prevented clients from linking to and/or engaging in HIV medical care and addresses these barriers through a standardized process including;

- intake,
- assessment,
- service plan development,
- service plan implementation,
- transition plan development and
- discharge.

The specific tasks performed by LTCS are defined by the unique barriers to care facing each client. The LTCS's primary responsibility is facilitating linkage and ultimate retention to HIV medical care and therefore is a key member of the client's care team. It is important for the LTCS to maintain regular communication with the team members to:

1. ensure client access to care;
2. assist with care coordination;
3. assist the client with developing a trusting relationship with the care team; and
4. create a smooth transition from LTC to case management or self-management.

The LTC program is designed to be a time-limited service that prepares clients to maintain engagement in HIV medical care through case management or self-management. The LTCS works with the client for no longer than nine months. During that period the client must attend at least three HIV medical visits with a prescribing provider. At intake, the client should be made to understand the time-limited nature of LTC services and that the goal for the client following LTC discharge is to continue engaging in HIV medical care by transitioning to self-management or case management services.

GOALS AND OBJECTIVES

The goals of the LTC program are consistent with the goals of the National HIV/AIDS Strategy.

Short Term Objectives

- Client attends at least three HIV medical visits over the course of nine months while enrolled in LTC services.
- Client increases independence and transitions to self-management or case management after completion of LTC services.

Long Term Goals

- Increase overall levels of client engagement in HIV medical care.
- Increase the number of individuals living with HIV in Wisconsin who are virally suppressed.

ROLE OF THE LINKAGE TO CARE SPECIALIST

The LTCS is a distinct member of the client's care team, separate from the HIV medical and/or non-medical case manager. Traditional HIV case managers utilize a generalist model to identify and address the full spectrum of the client's medical and non-medical needs. The LTCS works as a specialist with primary focus on identifying and addressing barriers that have prevented the client from engaging in HIV medical care and preparing the client to maintain engagement in medical care through case management or self-management after discharge from LTC services. Because each client will have a unique set of barriers, the individual tasks performed by the LTCS cannot be defined as a specific set of services.

When working with clients, the LTCS may identify client needs that are not directly related to preventing engagement in HIV medical care. The LTCS takes the lead in facilitating referrals to other members of the care team or other providers who are able to address these needs. The LTCS should monitor the status of any referrals made to ensure that the client's needs are being addressed. This requires regular and ongoing communication with members of the care team.

Regular communication between the LTCS and medical providers, case managers, and other service providers is necessary to avoid duplication of services and ensure each member understands their role within the team. More information on LTCS responsibilities regarding collaboration is provided in subsequent sections of this document, specifically the section entitled "Collaboration and Case Conferencing with Other Providers."

In addition to regular communication with service providers, the LTCS also maintains regular and ongoing communication with the client throughout the provision of LTC services. Because clients participating in LTC services have already identified barriers to engaging in care, efforts to maintain contact with LTC clients must be frequent and intensive. The LTCS utilizes varying contact methods and does not rely solely on contacting the patient via telephone. The LTCS facilitates regular face-to-face visits with the client which occur in settings most convenient for the client. More information on LTCS responsibilities regarding communication with clients is provided in the section entitled "Communication and Outreach with Clients."

Since the LTCS is focusing on addressing barriers that have prevented the client from engaging in HIV medical care, the LTCS role ends once the client has achieved early retention. Early retention is defined as client attendance at a minimum of three HIV medical visits with a prescribing provider. The LTCS may work with the client for up to nine months to achieve early retention. Prior to discharge from LTC services, the LTCS ensures that a comprehensive transition plan is in place which will allow the client to maintain engagement in HIV medical care through either self-management or case management.

CLIENT ELIGIBILITY CRITERIA

In order to receive LTC services, clients must meet eligibility criteria listed under one of the following groups:

Newly Diagnosed

Must meet all of the following criteria:

- a. First diagnosed with HIV infection during the previous 90 days.
- b. Has never received HIV-related medical care.
- c. HIV diagnosis complicated by other presenting issues including **but not limited to**:
 - i. Homelessness
 - ii. Pregnancy
 - iii. Recent HIV-related hospitalization
 - iv. Mental health and/or AODA crisis
 - v. Lack of insurance
 - vi. Language or cultural barriers
 - vii. Other perceived barriers identified by the referral source

New to Care

Must meet all of the following criteria under Group A or Group B:

Group A:

- a. First diagnosed with HIV infection more than 90 days ago.
- b. Has never received HIV-related medical care.

Group B:

- a. First diagnosed with HIV infection more than 90 days ago.
- b. Has received HIV medical care previously with a pediatric HIV medical provider.
- c. Transitioning to adult care from Primary Care Support Network

Out of Care

Must meet all of the following criteria:

- a. First diagnosed with HIV infection more than 90 days ago.
- b. Has received HIV medical care previously.
- c. Has not attended medical appointment with HIV medical provider in the previous 6 months.
- d. Does not have clinical treatment plan dictating only annual HIV medical appointment.

Post-Incarceration

Must meet all of the following criteria:

- a. Previously diagnosed with HIV infection.
- b. Incarcerated with scheduled release date OR released from DOC without notice.
- c. Residing in eligible Linkage to Care service area upon release.

At-Risk

Must be previously diagnosed with HIV infection and meet one or both of the following criteria:

- a. Has missed two or more consecutive HIV medical appointments.
- b. Has detectable viral load while on HIV medication.

Individuals who do not meet any of the criteria listed above are not eligible for LTC services and should be referred to traditional HIV case management.

REFERRALS

Referrals to the LTC program can come from a number of different sources. Once an LTCS has received a referral, it is their responsibility to determine whether or not the client meets LTC eligibility requirements and follow-up with the referral source regarding the outcome of the referral. The following charts illustrate referral patterns from the most common sources of LTC referrals including;

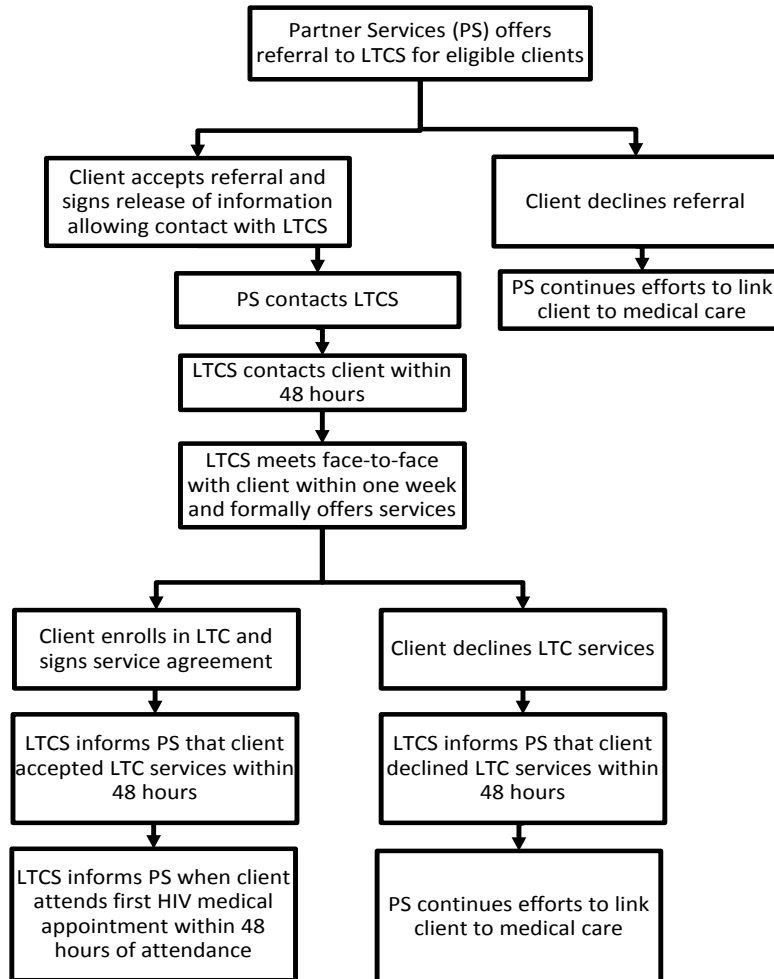
- Partner Services Staff
- Counseling, Testing and Referral Staff
- Medical Sites
- Corrections

The last chart in this section illustrates the steps the LTCS must take if they are unable to reach a client who has been referred to LTC services.

Referrals from Partner Services

A key responsibility for Partner Services (PS) is to help clients link to HIV medical care. The Partner Services worker can directly facilitate linkage with an HIV medical provider, or make a referral to an LTCS for clients who need additional assistance to make and attend their HIV medical appointments. Figure 2 illustrates how referral and communication should be coordinated between a PS agency and a LTCS.

Figure 2



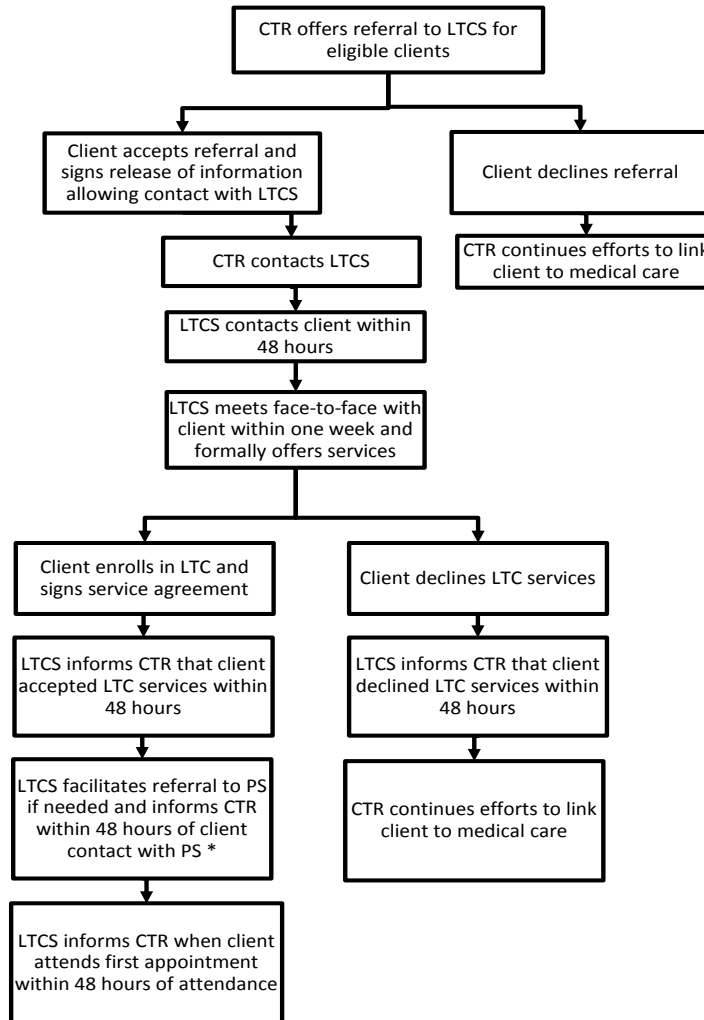
PS workers must adhere to State required standards and timelines. To ensure PS workers can meet these requirements, LTCS need to inform PS workers within 48 hours of 1) client declining to enroll in LTC services; 2) client accepting and enrolling in LTC services; 3) client attending first HIV medical appointment; and 4) when unable to establish contact with client after reasonable attempts have been exhausted.

If LTCS loses contact with client any time during the process outlined in Figure 2, refer to Figure 6 for instructions on how to proceed.

Referrals from Counseling, Testing and Referral (CTR) Sites

CTR workers are responsible for helping clients connect with PS and attend an initial HIV medical appointment. The CTR worker can directly facilitate linkage with these partners or make a referral to a LTCS for clients who need additional assistance. Figure 3 illustrates how referral and communication should be coordinated between a CTR agency and a LTCS. CTR staff may introduce themselves and explain LTC services to clients after an initial rapid reactive result.

Figure 3



CTR workers must adhere to State and Federal required standards and timelines. To ensure CTR workers can meet these requirements, LTCS need to inform CTR workers within 48 hours of 1) client declining to enroll in LTC services; 2) client accepting and enrolling in LTC services; 3) client contact with PS; 4) client attending first HIV medical appointment; and 5) when unable to establish contact with client after reasonable attempts have been exhausted.

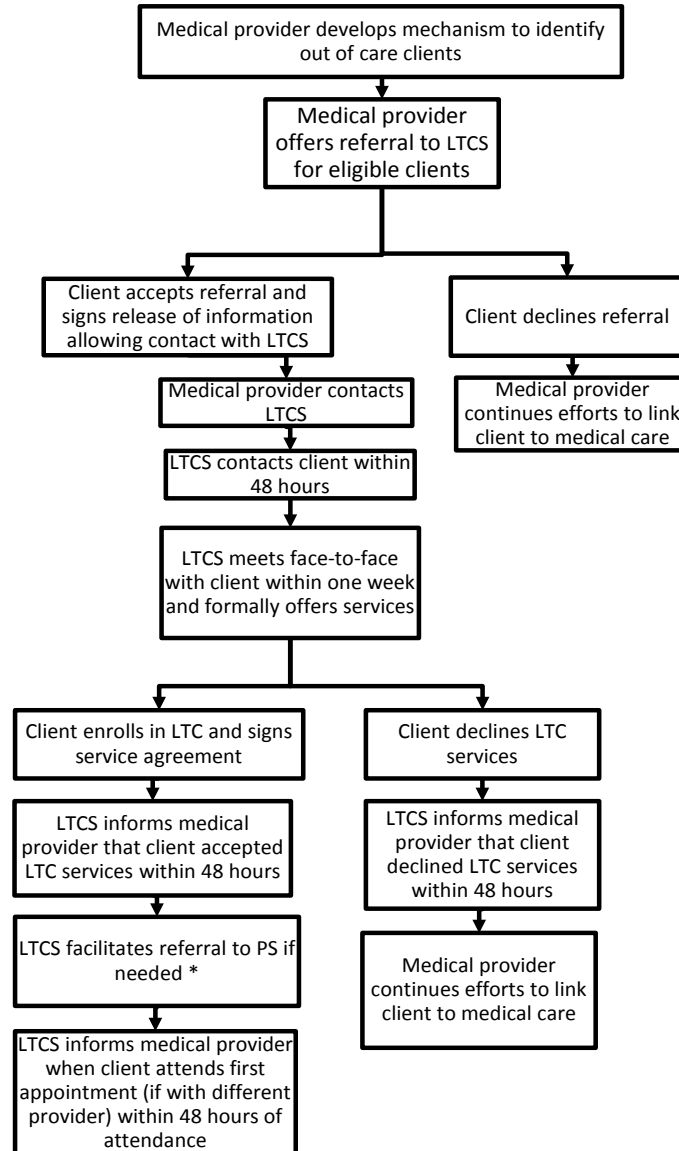
*When facilitating connections with PS, the LTCS collaborates with both local and state PS staff. The local PS worker and PS Coordinator in the AIDS/HIV Program need the following information 1) the client is newly diagnosed with HIV and 2) client information including demographics, date of diagnosis, and testing provider/agency.

If LTCS loses contact with client any time during the process outlined in Figure 3, refer to Figure 6 for instructions on how to proceed.

Referrals from Medical Sites

A medical site includes both outpatient clinics and inpatient hospitals. LTC clients in these settings have been identified by the medical provider as needing assistance to stay engaged in HIV medical care. The LTCS maintains regular communication with the client's medical care team to ensure care retention and prevent service duplication. Figure 4 illustrates how referral and communication should be coordinated between a medical site and a LTCS.

Figure 4



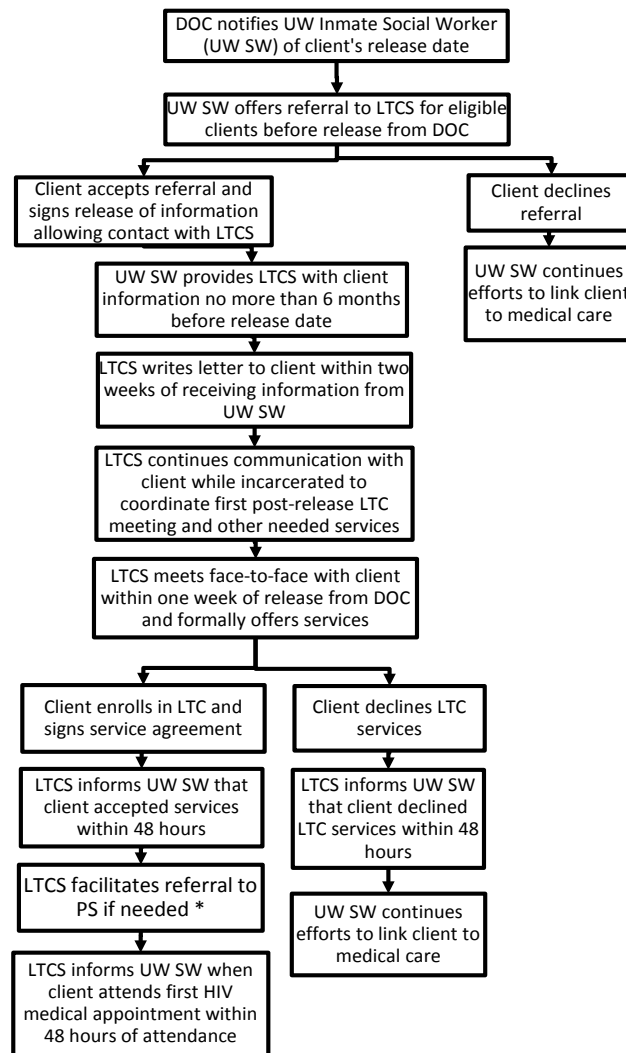
*When facilitating connections with PS, the LTCS collaborates with both local and state PS staff. The local PS worker and PS Coordinator in the AIDS/HIV Program need the following information 1) the client is newly diagnosed with HIV or was previously diagnosed and reports new partners and 2) client information including demographics, date of diagnosis, and testing provider/agency.

If LTCS loses contact with client any time during the process outlined in Figure 4, refer to Figure 6 for instructions on how to proceed.

Referrals from Corrections

HIV positive inmates in the Wisconsin Department of Corrections (DOC) have their care coordinated and provided through the University of Wisconsin Hospital and Clinics. Part of the care coordination involves the UW Inmate Social Worker (UW SW) who is responsible for coordinating the client's immediate medical needs upon release from DOC. This includes scheduling an initial medical appointment, obtaining two weeks of prescription medications, and enrolling the client in the AIDS Drug Assistance Program. After release from DOC, the LTCS works with the client to ensure engagement in medical care. Figure 5 illustrates how referral and communication should be coordinated between UW SW and a LTCS.

Figure 5



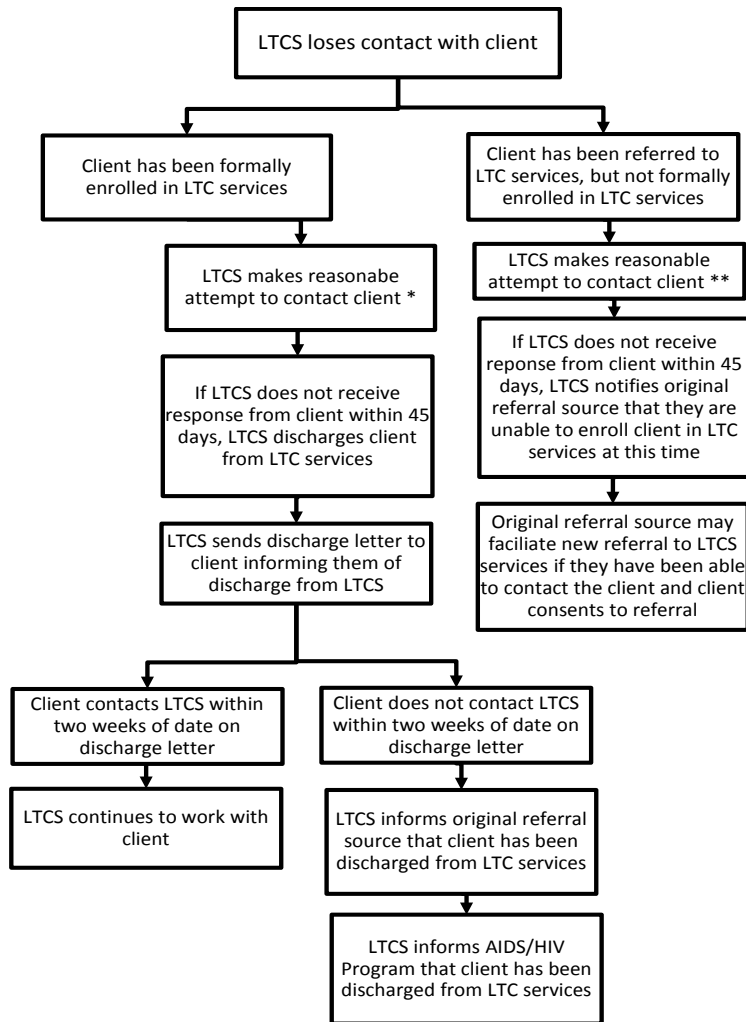
*When facilitating connections with PS, the LTCS collaborates with both local and state PS staff. The local PS worker and PS Coordinator in the AIDS/HIV Program need the following information 1) the client is newly diagnosed with HIV or was previously diagnosed and reports new partners and 2) client information including demographics, date of diagnosis, and testing provider/agency.

If LTCS loses contact with client any time during the process outlined in Figure 5, refer to Figure 6 for instructions on how to proceed.

Follow-up with clients who have lost contact with LTCS

Figure 6 illustrates how the LTCS should proceed if they lose contact with both clients who have been formally enrolled in LTC services, and those who have only been referred to LTC services.

Figure 6



* A reasonable attempt to contact clients who have formally enrolled in LTC services must include 20 contact attempts over the course of 45 days. These contact attempts must include both attempts to contact the client directly and attempts to contact any appropriate collateral contacts. Documentation of attempts must show that a variety of contact methods were used including; phone calls, text messages, letters, emails, and/or unannounced visits.

** A reasonable attempt to contact clients who have been referred to LTC services but not formally enrolled must include 10 contact attempts over the course of 45 days. These attempts may all be made directly to the client. Varied contact methods to reach the client should be used if this information is available to the LTCS.

COLLABORATION AND CASE CONFERENCING WITH OTHER PROVIDERS

Collaboration between the LTCS and other providers working with the client is imperative in order to achieve stated goals and avoid service duplication. The LTCS fosters collaboration through regular communication, information sharing, and case conferencing with the following service providers throughout the provision of LTC services:

1. LTC Referral Sources
 - Counseling, Testing and Referral (CTR) and Partner Services (PS)
 - Medical case managers or other clinical staff
 - Non-medical case manager
 - Department of Corrections/ UW Inmate social worker
 - Wisconsin AIDS/HIV Program

2. Client's HIV Care Team
 - HIV clinic providers/staff
 - Medical case manager
 - Non-medical case manager

3. Post LTC Discharge Case Manager (if applicable)
 - Medical case manager
 - Non-medical case manager
 - Brief services provider

Case conferencing, a more formal, planned, and structured event separate from regular contacts, is a critical part of effective collaboration. Case conferences can be used to:

- identify or clarify issues regarding a client's status, needs, and goals;
- review activities including progress and barriers towards goals;
- map roles and responsibilities;
- resolve conflicts or strategize solutions; and
- discuss service and transition plans.

Case conferences are usually interdisciplinary, and include one or multiple internal and external providers and, if possible and appropriate, the client. It is preferable for case conferencing to be done face-to-face; however it may also be done via phone or video conference.

Standard	Criteria
Throughout the provision of LTC services, the LTCS ensures collaboration and coordination with the LTC referral source, the client's HIV care team and the post LTC discharge case manager.	<ol style="list-style-type: none"> 1. Contact with the LTC Referral Source: <p>The LTCS informs the LTC referral source within 48 hours of the following events:</p> <ul style="list-style-type: none"> • Client accepts and enrolls in LTC services • Client declines LTCS service • Client attends first HIV medical appointment • Client has contact with PS (report only if referral source was CTR) • LTCS unable to establish contact with client after reasonable attempt has been exhausted

	<p>2. Contact with the HIV Care Team:</p> <p>The LTCS maintains regular communication with the client's HIV Care Team throughout the provision of LTC services.</p> <p>Communication may occur via phone, email or face-to face case conferencing.</p> <ul style="list-style-type: none">• The LTCS explains their role to members of the HIV care team.• The LTCS ensures that efforts are coordinated between members of the care team to reduce duplication of services. <p>3. Contact with the Post LTC Discharge Case Manager:</p> <p>If the client's goal is to transition to case management after discharge from LTC services, the LTCS must facilitate a minimum of two case conferences before discharge. One case conference must be face-to-face with LTCS, client and case manager present.</p> <ul style="list-style-type: none">• The LTCS communicates regularly with the case manager between case conferences to further prepare for transition, implement the LTC service plan, and avoid duplication of services.
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COMMUNICATION AND OUTREACH WITH CLIENTS

The LTCS explains to the client that participation in LTC services requires frequent and intensive contact between the client and the LTCS. Methods for contacting clients must vary. The LTCS facilitates regular face-to-face visits with the client to establish rapport and keep the client engaged in HIV medical care. Face-to-face visits occur in settings most convenient for the client and are not solely office or clinic-based.

Standard	Criteria
<p>The LTCS identifies various methods of contacting the client and maintains regular contact with clients throughout the provision of services.</p> <p>If the LTCS loses contact with either a client who has been referred to LTC or a client who has enrolled in LTC, the LTCS makes a reasonable attempt to contact the client before ceasing work with the client.</p>	<ol style="list-style-type: none"> 1. If unable to reach a client <i>referred</i> to LTC services, the LTCS makes a reasonable attempt to contact the client before informing LTC referral source that the referral has been closed. <p>A reasonable attempt to contact clients who have been <i>referred to LTC services but not formally enrolled</i> must include 10 contact attempts over the course of 45 days.</p> <ul style="list-style-type: none"> • These attempts may all be made directly to the client. • Varied contact methods to reach the client should be used if this information is available to the LTCS <p>LTC referrals to clients who are unresponsive to these attempts after 45 days will be closed by the LTCS.</p> 2. Once a client enrolls in LTC services, the LTCS utilizes the LTC Client Locator Form (Appendix B) at intake to discuss and document: <ul style="list-style-type: none"> • Expectations for client and LTCS communication • Client contact information • Emergency contact • Contact information for friends/family • Contact information for service providers • Addresses where LTCS can mail letters or make unannounced visits <p>The LTCS updates the LTC Client Locator and corresponding releases of information throughout the provision of LTC services.</p> 3. If unable to reach a client <i>enrolled</i> in LTC services, the LTCS makes a reasonable attempt to contact the client before discharging them from LTC services. <p>A reasonable attempt to contact clients who have <i>formally enrolled</i> in LTC services must include 20</p>

	<p>contact attempts over the course of 45 days.</p> <ul style="list-style-type: none"> • These contact attempts must include both attempts to contact the client directly and attempts to contact any appropriate collateral contacts. • Documentation of attempts must show that a variety of contact methods were used including: phone calls, text messages, letters, emails, and/or unannounced visits. • Contact attempt must result in client engagement in services in order for 45 day period of “no contact” to restart. <p>Clients who have been unresponsive to these attempts after 45 days will be discharged from LTC services.</p> <p>4. The LTCS has frequent face-to-face contact with the client in locations that are most convenient for the client.</p> <p>At least one visit must occur in the client’s home or other community-based setting if the client consents.</p> <p>5. Face-to-face contact between LTCS and client occurs at:</p> <ul style="list-style-type: none"> • intake, • assessment, • service plan development, • throughout service plan implementation, • transition plan development, and • transition plan finalization and discharge.
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INTAKE

Intake occurs during an initial meeting with the client. During intake the LTCS explains the scope of LTC services and expectations for client participation in the program. The LTCS gathers information on the client's immediate barriers to care by conducting the LTC Client Barrier Survey and determines whether the client is appropriate for LTC services. The client agrees to an agency-specific service agreement to indicate enrollment in LTC services (this may be completed before intake). If the client does not meet LTC eligibility criteria or identify any barriers to engagement in HIV medical care, the LTCS facilitates referral to case management services.

<i>Standard</i>	<i>Criteria</i>
<p>Key information is documented to determine the client's main barriers to HIV medical care and whether the client is appropriate for LTC services.</p> <p>The LTC Client Barrier Survey is conducted with the client.</p> <div data-bbox="256 909 594 1140" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Time Requirement:</p> <p>Completed within 14 days of service agreement completion.</p> </div>	<ol style="list-style-type: none"> 1. Intake documentation includes: <ol style="list-style-type: none"> A. State Intake Form (Appendix A) <ul style="list-style-type: none"> • Client name • Agency specific client ID • Date of birth • Gender • Client type • Referral source B. Linkage to Care Client Locator Form (Appendix B) <ul style="list-style-type: none"> • Client contact information • Emergency contact • Contact information for friends/family • Contact information for service providers • Addresses where LTCS can mail letters or make unannounced visits C. Releases of Information <ul style="list-style-type: none"> • Agency specific • Signed by client for all listed contacts D. Service Agreement <ul style="list-style-type: none"> • Agency specific E. Linkage to Care Client Barrier Survey (Appendix C) 2. Information collected on the State Intake Form, LTC Client Locator Form and Releases of Information is documented in the client's chart. 3. Copies of the State Intake Form and LTC Client Barrier Survey are sent to the AIDS/HIV Program for evaluation purposes. 4. If client is deemed inappropriate for LTC, the reason is documented in the client chart and signed by LTCS supervisor. LTCS facilitates

	referral to case management services.
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ASSESSMENT

The assessment expands on information gathered during Intake, specifically information related to the client’s barriers to accessing or engaging in HIV medical care.

<i>Standard</i>	<i>Criteria</i>
<p>An assessment describes in detail the client’s medical and non-medical conditions and needs that may prevent or have prevented linkage and retention to HIV medical care. Assessment also identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated.</p> <p>The assessment identifies the client’s resources and strengths, including family and other supports which can be utilized during service planning.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 20px;"> <p>Time Requirement:</p> <p>Completed within 14 days of service agreement completion.</p> </div>	<p>1. Assessment documentation includes:</p> <p style="margin-left: 20px;">A. Case Management Comprehensive Assessment (Appendix D)</p> <p style="margin-left: 20px;">LTCS are only required to complete shaded areas of the Assessment as outlined in Appendix D</p> <p style="margin-left: 20px;">Shaded areas include information related to:</p> <p style="margin-left: 20px;"><i>Core Services</i></p> <ul style="list-style-type: none"> • HIV disease progression • Sexually transmitted diseases • Other medical conditions • OB/GYN, including current pregnancy status • Medications and adherence • Allergies to medications • Alcohol/drug use/smoking history and current status • Mental health • Current health care providers; engagement in and barriers to care <p style="margin-left: 20px;"><i>Support Services</i></p> <ul style="list-style-type: none"> • Financial resources and entitlements • Transportation • Support systems • Parenting needs • Partner notification needs (PS) • HIV disclosure status/issues • Domestic violence • Legal needs • Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission • Employment/education <p style="margin-left: 20px;"><i>Additional Information</i></p> <ul style="list-style-type: none"> • HIV verification

	<ul style="list-style-type: none">• Copy of photo identification (driver's license, passport, etc.) if client has one• Copy of Insurance card• Proof of income and residency• Other agencies serving client• Name of person completing the assessment and date of completion <ol style="list-style-type: none">1. The LTCS has primary responsibility for completing the assessment and meets face-to-face with the client to complete the assessment process.2. Information collected on the Case Management Comprehensive Assessment is documented in the client's chart.
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SERVICE PLAN DEVELOPMENT

Service planning is a critical component of LTC services and provides the client, LTCS, and rest of the care team with a concrete, step-by-step approach to address client barriers to accessing and engaging in HIV medical care.

The Service Plan serves additional functions, including:

- focusing client and LTCS on priorities,
- assisting clients in negotiating service delivery systems,
- serving as a tool to evaluate accomplishments and barriers; and
- determining timeline and goal for transition to either case management or self-management following LTC discharge.

The client is actively engaged in the development, implementation, and evaluation of the service plan and may include participation of family, close support persons and other providers.

Standard	Criteria
<p>Barriers to engagement in medical care identified by the client and/or LTCS during assessment are prioritized and translated into a service plan which defines specific action steps to address barriers.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time Requirement: Completed within 14 days of service agreement completion.</p> </div>	<ol style="list-style-type: none"> 1. Service Plan documentation includes: <ol style="list-style-type: none"> A. Linkage to Care Service Plan (Appendix E) <ul style="list-style-type: none"> • Transition goal • Barriers to engaging in HIV medical care • Action steps to address barriers • Individual responsible for action steps • Action step start date • Action step end date • Status of action step at end date • Client, LTCS, and LTCS supervisor signatures signifying agreement and approval documented 2. The LTCS has primary responsibility for the development of the service plan. 3. Information collected on the LTC Service Plan must be documented in the client's chart.

SERVICE PLAN IMPLEMENTATION

The majority of the LTCS' work occurs in the implementation of the service plan. Implementation involves carrying out the action steps listed in the service plan. Activities performed during implementation will vary based on the barriers to care identified by the client; however, all service plan implementation requires scheduling of HIV medical appointments, preparing clients for medical appointments, attending medical appointments, and coordinating efforts with the client's care team.

<i>Standard</i>	<i>Criteria</i>
<p>Implementation of the action steps outlined in the LTC Service Plan proceeds immediately after its development.</p> <p>Specific activities completed in the implementation phase will vary based on the unique barriers identified by each client.</p> <p>Core activities for effective implementation of the service plan include scheduling and preparing the client for HIV medical appointments, attending HIV medical appointments with the client, and coordinating efforts with the client's care team.</p> <div data-bbox="256 1255 602 1472" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time Requirement: Completed prior to LTC discharge and transition, no more than 9 months after completion of service agreement.</p> </div>	<p>1. Core Service Plan Implementation includes:</p> <p>A. Scheduling HIV Medical Appointments</p> <ul style="list-style-type: none"> • LTCS assists the client in scheduling the first and second HIV medical appointments while explaining and modeling the process to the client. • The client independently schedules third and subsequent appointments. <p>B. Preparing the Client for HIV Medical Appointments</p> <ul style="list-style-type: none"> • LTCS discusses what the client can expect during the visit. • LTCS assists client in preparing a list of questions they want to ask the provider. • LTCS encourages the client to fully participate in the medical appointment. • LTCS confirms plans for transportation and meeting with the client. • LTCS contacts the client before their appointment to remind the client of appointment date and time. • LTCS works with the client to develop a sustainable transportation plan for future appointments. <p>C. Attending HIV Medical Appointments</p> <ul style="list-style-type: none"> • With the client's consent, the LTCS attends the first medical appointment with the client. • LTCS attends the second and third medical appointments if the client requests. • At the appointment, the LTCS acts as a support and advocate for the client and leaves the exam room when requested to do so by the client or medical provider.

	<p>D. Coordination with the Care Team</p> <ul style="list-style-type: none">• LTCS is responsible for introducing themselves to the care team and explaining their role.• LTCS maintains regular ongoing contact with appropriate members of the client's care team. <ol style="list-style-type: none">2. The LTCS must document the status (attended, canceled, missed) of all HIV medical appointments in the client's chart.3. The LTCS must document all encounters with or on behalf of the client in the clients chart and on the LTC Daily Encounter Form (Appendix F).4. Copies of the Daily Encounter Form must be sent to the AIDS/HIV Program weekly.
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SERVICE PLAN REVIEW

Due to the time-limited nature of LTC services, the LTCS refers to the service plan and progress towards service plan goals is reviewed during all interactions with the client. LTC service plans are updated as action steps are completed or as the client's life circumstances change. Formal reviews between the LTCS and LTCS supervisor occur at regularly scheduled intervals.

<i>Standard</i>	<i>Criteria</i>
<p>Service plans are reviewed and updated regularly both with the client and LTCS supervisor.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time Requirement:</p> <p>Update status at each action step end date.</p> <p>Formal review with LTCS supervisor at 1 and 6 months after LTC enrollment.</p> </div>	<ol style="list-style-type: none"> 1. The service plan is reviewed regularly with the client to check the progress of actions steps. 2. The LTCS updates and documents the status of an action step at each estimated end date listed on the service plan. 3. Formal review of the service plan between LTCS and LTCS supervisor occurs: <ul style="list-style-type: none"> • within the first month of client's engagement in LTCS services • after client has been engaged in LTC services for six months

TRANSITION PLAN DEVELOPMENT

Transition plans are critical in sustaining client retention in care beyond discharge from LTC services. The client is aware from point of intake that LTC services are time-limited and transition to self-management or case management will occur once retention is achieved. The transition plan serves as a tool to identify barriers that have been addressed during LTC, as well as unresolved issues requiring action post LTC discharge.

<i>Standard</i>	<i>Criteria</i>
<p>Transition to self-management or case management is discussed throughout the provision of LTC services.</p> <p>Transition plans are created for each client prior to discharge.</p> <div data-bbox="256 814 602 1052" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Time Requirement:</p> <p>Case conferencing with case manager occurs twice before discharge.</p> </div>	<ol style="list-style-type: none"> 1. Transition Plan (Appendix G) documentation includes: <ul style="list-style-type: none"> • Date of transition • Type of transition (self-management, brief services, non-medical case management, medical case management) • Summary of issues resolved during enrollment in LTC • Summary of unresolved issues requiring action • Individual responsible for addressing unresolved issue (client, case manager) • Signature of client, LTCS and new case manager (if applicable) indicating approval 2. If the client's goal is to transition to case management after discharge from LTC services, the LTCS must facilitate a minimum of two case conferences before discharge. One case conference must be face-to-face with LTCS, client and case manager present. <p>During the final case conference:</p> <ul style="list-style-type: none"> • LTCS, client and case manager sign off on the final transition plan. The LTCS supervisor also signs off on transition plan but does not need to be present at the case conference. 3. Information collected on the transition plan is documented in the client's chart.

DISCHARGE

The LTCS works with the client for a maximum of 9 months. In that time, it is expected that the client establishes early retention by attending at least three HIV medical visits while enrolled in LTC services.

There is no minimum amount of time that the client must be enrolled in LTC services; however the client should attend a minimum of three HIV medical visits before discharge. If the client is discharged before attending three medical visits, the LTCS must document the reason for discharge in the client chart.

Reasons for discharge other than program completion include:

- Client relocates outside of service area.
- Client chooses to terminate service.
- Client is lost to care or does not engage in service after LTCS has made reasonable attempt to contact client.
- Client is incarcerated.
- Agency initiated termination due to behavioral violations.
- Client death.

<i>Standard</i>	<i>Criteria</i>
<p>Upon completion of active LTC services and LTC Transition Plan, a client is discharged and transitioned to self-management or case management.</p> <p>A second LTC Client Barrier Survey must be completed at time of discharge.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Time Requirement:</p> <p>Client enrolled in LTC services for maximum of 9 months. Must attend at least 3 HIV medical visits during this time.</p> <p>Follow-up with case manager or self-managed clients 3 months and 6 months post LTC discharge to assess engagement in HIV medical care.</p> </div>	<ol style="list-style-type: none"> 1. Discharge documentation includes: <ol style="list-style-type: none"> A. State Discharge Form (Appendix H) <ul style="list-style-type: none"> • Agency specific client ID • Reason for discharge • Discharge service level B. Completed Transition Plan <ul style="list-style-type: none"> • Reviewed and signed by client, LTCS, case manager (if applicable) and LTCS supervisor C. Completed LTC Client Barrier Survey (Appendix C) 2. If unable to reach a client enrolled in LTC services, the LTCS makes a reasonable attempt to contact the client before discharging them from LTC services. <p>A reasonable attempt to contact clients who have formally enrolled in LTC services must include 20 contact attempts over the course of 45 days.</p> <ul style="list-style-type: none"> • These contact attempts must include both attempts to contact the client directly and attempts to contact any appropriate collateral contacts. • Documentation of attempts must show that a variety of contact methods were used including; phone calls, text messages, letters, emails, and/or unannounced visits. • Contact attempt must result in client engagement in services in order for 45 day period of “no contact” to restart.

	<p>Clients who are unresponsive to these attempts after 45 days will be discharged from LTC services.</p> <p>3. All clients discharged from LTC services receive a discharge letter explaining reason for discharge.</p> <p>Letter to clients who have completed LTC services include:</p> <ul style="list-style-type: none"> • name and contact information for case manager (if applicable), and • a copy of LTC Transition Plan. <p>Letter to clients who have not completed LTC services must include:</p> <ul style="list-style-type: none"> • contact information for HIV case management and clinical services, and • notification that the client may reengage in LTC services if the client contacts the LTCS within two weeks of date of discharge letter. <p>4. In the event of client death, referral information about grief counseling or other support services is shared with client's family and/or significant others.</p> <p>5. The discharge letter, State Discharge Form and Finalized Transition Plan, and LTC Client Barrier Survey is documented in the client's chart.</p> <p>6. A copy of the State Discharge Form and completed LTC Client Barrier Survey is sent to the AIDS/HIV Program.</p> <p>LTCS Follow-Up Post Discharge</p> <p>2. For clients who have transitioned to case management the LTCS must:</p> <ul style="list-style-type: none"> • contact the assigned case manager 3 months and 6 months post LTC discharge to discuss the client's current level of engagement in HIV medical care. • readmit the client to LTC services if case manager informs LTCS that client has had repeated episodes of non-adherence to treatment plan. <p>3. For clients who have transitioned to self-management the LTCS must:</p> <ul style="list-style-type: none"> • contact the discharged client 3 months and 6
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	<p>months post LTC discharge to assess the client's current level of engagement in HIV medical care.</p> <ul style="list-style-type: none">• readmit the client to LTC services if the client reports repeated episodes of non-adherence to treatment plan.• refer the client to case management services if they require some assistance, but not intensive LTC services. <p>Readmission</p> <ol style="list-style-type: none">1. Clients who have been previously discharged from LTC services may be readmitted if they have shown repeated episodes of non-adherence to their treatment plan since discharge and are referred by an LTC referral source.2. Once re-enrolled in LTC services the LTCS:<ul style="list-style-type: none">• completes a new State Intake Form• ensures that the client completes a new LTC Barrier Survey• completes Assessment Form if more than 6 months have elapsed since last enrollment in LTC Services• updates the LTC Service Plan• updates the Client Locator Form
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CONFIDENTIALITY STANDARDS

The Wisconsin AIDS/HIV Program emphasizes the importance of client confidentiality in service delivery. Confidentiality ensures that information regarding a client's HIV status, behavioral risk factors, or use of services cannot be released without the client's documented consent.

The AIDS/HIV Program has established written guidance in compliance with HIPAA and State of Wisconsin confidentiality laws surrounding health related information. HIV care providers and agencies are required to ensure that their practice conforms to these policies and procedures.

PROCEDURES

A. For collateral communication and care coordination on behalf of the client.

Upon entry into linkage to care services, each client completes the following documentation:

1. Consent to Enroll in Linkage to Care Services.
2. Client Rights and Responsibilities Form (including client's responsibility to maintain the confidentiality of other agency consumers).
3. Written Release of Information for all exchange of health related information and documented verbal authorization for all verbal communication related to the consumer.

B. For electronic record maintenance.

When a client file is generated, the following guidelines are strictly followed:

1. Access to electronic records are password protected and access is limited to staff members with demonstrated need for the information.
2. Screensavers on computers are password protected and active for less than 10 minutes.
3. Staff members do not share passwords for consumer protected information with anyone.

C. For paper record maintenance

When a client file is generated, the following guidelines are strictly followed:

1. All materials are maintained in a locking file cabinet or drawer within a locked office or room.
2. Files are locked at all times when not immediately in use.
3. All record documentation is maintained for a minimum of 7 years following case closure or inactivation and then disposed of with cross-cutting shredding specifically designed for destruction of confidential information.

D. Transport of records from secure office or location

When files, either electronic or paper need to be transported to an alternate location, the following guidelines are strictly followed:

1. Electronic files may be transported temporarily via a password protected device (USB external drive, etc.).
2. Once the electronic files have been reviewed or edited, updates are made to the central database and then deleted (formatted) from the temporary drive.
3. External drive or data storage device do not leave the possession of the linkage to care staff at any time and the linkage to care specialist assumes full responsibility for the protection of the data.
4. Paper files transported to an alternate location for the purposes of case review or auditing are maintained in a locking file folder or other secure device.
5. Once the files have been reviewed the documents are either returned to a location with a double lock system or disposed in accord with the guidelines listed above regarding disposal of confidential information.

DOCUMENTATION

Client charts and electronic files are legal documents and are maintained for the purposes of internal organization and auditing and external auditing. For legal and auditing purposes, if no record of an event or incident is found, then the event/incident did not occur. Accurate record keeping not only ensures a higher quality of care but also protects the service provider by documenting every action taken on the client's behalf. The following guidance has been drafted from established social work standards for chart documentation and etiquette.

A. Record keeping

The following information **is required to** be kept in client charts for the purposes of reporting and auditing:

- Demographic information
- Client Locator Form - Appendix B
- Releases of Information
- State Intake Form - Appendix A (copy sent to AIDS/HIV Program)
- LTC Barrier Survey completed at Intake and Discharge Appendix C (copies sent to AIDS/HIV Program)
- Comprehensive Case Management Assessment- Appendix D
- LTC Service Plan - Appendix E
- Progress notes
- Daily Encounter Form - Appendix F (copies sent to AIDS/HIV Program)
- Status of all HIV medical appointments (attended, canceled, missed)
- Transition Plan - Appendix G
- State Discharge Form - Appendix H (copy sent to AIDS/HIV Program)

State Intake Form, State Discharge Form, LTC Barrier Survey, and Daily Encounter Form must be used in the format created by the AIDS/HIV Program. Electronic or other systems may be used for other forms if all information on the templates created by the AIDS/HIV Program is captured in the alternative system.

B. Progress notes

The Linkage to Care Specialist is required to write a progress note in the client's chart each time an encounter occurs with or related to the client, including but not limited to:

- Each incident of client contact (in-person meeting, phone, email, etc.)
- Each collateral contact
- Service distribution to the client
- Receipt of any paper work or information from consumer or third party

The content of a progress note is subject to the following guidelines:

- Keep the note concise and to the point (information should be relevant to the client's progress towards goals, or concerns/barriers that are impeding progress)
- Include date that the encounter occurred
- Define specific terms especially abbreviations or maintain an agency-wide standard definition for consistency
- Notes should be objective or "judgment neutral"
- Note should be non-diagnostic, noting only the author's observation (e.g. "Consumer was stumbling and slurring his words" rather than "Consumer was drunk")
- Write in third person (e.g. case manager met with consumer this afternoon)

C. Daily Encounter Form

In addition to progress notes, the LTCS is also required to complete Daily Encounter Forms for each client. This is required by the SPNS ETAC for evaluation purposes.

The daily encounter form tracks the duration (face-to-face, telephone) and quantity (email, text messages, letters) of work spent with or on behalf of the client in the following areas;

- Attending HIV medical appointments
- Transporting clients to HIV medical appointments
- HIV Medical
- Mental health
- AODA
- Housing
- Financial/Income
- Benefits/Insurance
- Transportation

Copies of all daily encounter forms must be sent to the AIDS/HIV Program for reporting purposes.

CASELOADS AND SUPERVISION

An average LTCS caseload consists of 15 clients. This number does not include corrections clients who have not yet been released and clients that are yet to be located or have not yet enrolled in LTC services.

All LTCSs are required to have an onsite supervisor who has a background and extensive experience with HIV service delivery systems. Supervisors are responsible for initial and ongoing training of LTCSs as well as completion of annual performance reviews.

At a minimum, supervisors meet with the LTCS:

- after the initial creation of the LTC service plan,
- after a client has been a program participant for 6 months,
- prior to discharge from LTC services and transition to self-management or case management, and
- when necessary (recommended monthly) to discuss client caseload progress, program issues, monitoring and evaluation forms, assistance with referrals, etc.

TRAINING REQUIREMENTS

Each agency is responsible for providing new Linkage to Care Specialists and supervisors with job-related training that commences within 15 working days of hire and is completed no later than 90 days following hire. Training should include provision of agency policies and procedures manual and employee handbook as well as job shadowing for core linkage to care specialist activities and performance monitoring during probationary period. Included in the probationary period, new linkage to care specialists should be monitored for satisfactory completion of linkage to care specific tasks such as assessments, service plan completion and client counseling sessions. These activities should be monitored in person by appropriate supervisory staff at least once before linkage to care specialist is approved to provide services independently. A record of the training provided must be included in each linkage to care specialist's personnel file. The record should indicate specific training topics, completion date and the employee's initials next to each training topic.

All new Linkage to Care Specialists must complete the following trainings offered by the University of Wisconsin HIV Training System within a year of hire;

- HIV Basics (Online)
- HIV Counseling Skills
- New Case Manager Orientation and Training

In addition, all Linkage to Care Specialists must participate and attend all LTCS conference calls and Quarterly Training Sessions hosted by the AIDS/HIV Program and complete a minimum of 10 hours of continuing education annually. Pre-approved trainings are provided through the University of Wisconsin HIV Training System (<http://www.wihiv.wisc.edu/trainingsystem/>). Trainings offered outside of the HIV Training System can be applied toward the requirement if they meet the following criteria:

- training related to enhancing job performance of case managers/social workers, specifically in the HIV field (including conferences and workshops)
- training that offers CEUs or equivalent

APPENDIX A: State Intake Form

STATE INTAKE FORM

Date of Intake:	
CLIENT DEMOGRAPHICS	
First Name:	Last Name:
AKA (if applicable):	
Client ID (agency specific):	Date of Birth:
Current Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> MTF <input type="checkbox"/> FTM <input type="checkbox"/> Unknown	
*SSN:	
Risk Factor: <input type="checkbox"/> MSM <input type="checkbox"/> MSM and IDU <input type="checkbox"/> IDU <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
*Race:	
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify): <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African American/Black <input type="checkbox"/> Not Reported	
*Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Not Reported	

LTC ENROLLMENT INFORMATION	
LTCS Name:	Enrollment Date:
Client Type: <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> New to Care <input type="checkbox"/> Out of Care <input type="checkbox"/> Post-incarceration	
<input type="checkbox"/> At-Risk (select all that apply): <input type="checkbox"/> Client missed two consecutive HIV medical appointments. <input type="checkbox"/> Client has detectable viral load and is on HIV medication.	
Referral Source Type:	
<input type="checkbox"/> Testing Site <input type="checkbox"/> Inpatient Setting <input type="checkbox"/> LTCS Transfer <input type="checkbox"/> Partner Services <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> DOC/ DOC release date: <input type="checkbox"/> WI AIDS/HIV Program <input type="checkbox"/> Community Organization <input type="checkbox"/> UW Inmate Social Worker/ DOC release date: <input type="checkbox"/> Case Manager <input type="checkbox"/> Other (specify):	
Name of Referring Agency:	Date of Referral:

MEDICAL PROVIDER	
Provider Name:	
Provider Location:	

CLIENT INFORMATION	
Current Housing Status: <input type="checkbox"/> Stable/Permanent <input type="checkbox"/> Unstable <input type="checkbox"/> Temporary <input type="checkbox"/> Unknown	
Current Insurance Status (select all that apply):	
<input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid Medical Home <input type="checkbox"/> No insurance <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify):	

LTC Client Barrier Survey Completed

<p>Mail copy of completed Intake Form and LTC Client Survey to : Attn: Franela Ngaboh-Smart Division of Public Health 1 West Wilson Street, Rm 265 Madison, WI 53701</p>	<p>*LTCS are not required to report these fields to the state. These fields were included to assist LTCS with information gathering.</p> <p>Please redact client's SSN before sending copy of Intake Form to the State HIV/AIDS Program</p> <p style="text-align: right; font-size: small;">Revised 1/30/14</p>
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APPENDIX B: Linkage to Care Client Locator Form

INSTRUCTIONS: Linkage to Care Client Locator Form

- The Linkage to Care Specialist uses a variety of methods to reach clients who have been lost to follow-up or are no longer engaging in Linkage to Care Services.
- This form acts as a tool to identify ways the Linkage to Care Specialist can contact the client if unable to reach the client by phone.
- This form is completed with the client at time of Linkage to Care intake.
- The Linkage to Care Specialist reads the introductory statement to the client and then works with the client to complete the rest of the form.
- This form does not serve as a release of information (ROI). Every contact listed by the client in Tables 1-4 must have a corresponding ROI (agency-specific) signed by the client. All ROIs should be kept in the client's chart.
- The Linkage to Care Specialist should review and update this form and corresponding ROIs throughout the client's enrollment in Linkage to Care Services.

LINKAGE TO CARE CLIENT LOCATOR INFORMATION FORM

The purpose of the Linkage to Care Specialist is to work with you so that you are able to stay actively involved in medical care. Being actively involved in medical care means attending all scheduled clinic visits, taking medications as prescribed and following other suggestions made by your medical providers. In order for your Linkage to Care Specialist to assist you with this, it is important that they have regular contact with you.

CLIENT INFORMATION

NAME:	DATE:	
AKA:		
ADDRESS:	COUNTY:	
CITY/TOWNSHIP:	STATE:	ZIP:
HOME PHONE :		
May we leave a message: <input type="checkbox"/> Yes-detailed <input type="checkbox"/> Yes-discreet <input type="checkbox"/> No		
Preferred contact method: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message		
CELL PHONE:		
May we leave a message: <input type="checkbox"/> Yes-detailed <input type="checkbox"/> Yes-discreet <input type="checkbox"/> No		
Preferred contact method: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message		
WORK PHONE:		
May we leave a message: <input type="checkbox"/> Yes-detailed <input type="checkbox"/> Yes-discreet <input type="checkbox"/> No		
Preferred contact method: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text Message		
EMAIL ADDRESS:		
EMERGENCY CONTACT:	PHONE:	RELATION:
	AWARE OF STATUS:	ROI:

In the event that I am not actively involved in my medical care and my Linkage to Care Specialist has been unable to reach me using any of the above contact information I give permission for them to:

1. Contact the following friends or family members by phone:

Name	Relation	Phone	Leave Message (Y/N)	Aware of Status (Y/N)	ROI SIGNED (Effective date/Expiration date)

2. Contact the following members of my care team by phone:

Name	Title	Phone	Leave Message (Y/N)	Aware of Status (Y/N)	ROI SIGNED (Effective date/Expiration date)
	Case Manager				
	Doctor's Office				
	Pharmacy				
	MH Provider				

3. Mail a letter to the following addresses:

Care of	Address	Aware of Status (Y/N)	ROI SIGNED (Effective date/Expiration date)
Client			

4. Visit the following addresses without providing prior notification:

Occupant/Agency/Business	Address	Aware of Status (Y/N)	ROI SIGNED (Effective date/Expiration date)
Client			

Client or guardian: _____ Date: ___/___/___

Linkage to Care Specialist: _____ Date: ___/___/___

APPENDIX C: Linkage to Care Client Barrier Survey

Instructions for LTC Client Barrier Survey

1. LTCS should start using the LTC Client Barrier Survey (version presented at the LTC Quarterly meeting on 1/15/14) with all new clients immediately. LTC Client Barrier Survey should also be completed for any existing clients with an LTC Intake date of 12/15/13 or later.
2. The client should complete the LTC Client Barrier Survey at Intake and Discharge. If the client refuses to complete the survey, please make a note on the survey form and send to Franella.
3. Copies of the completed surveys attached either to the client's Intake or Discharge form must be sent to Franella.
4. The LTCS should go through the survey step-by-step with client. Start by reading the shaded box at the top of the form which explains the survey. The LTCS should then read each of the statements to the clients, discuss any questions the client may have regarding the statement and provide further explanation if needed, and mark the client's answer on the survey form.
5. Some statements are related to the clients' past experiences attending medical appointments. For newly diagnosed clients who have not yet attended medical appointments, the LTCS should frame the statement as a belief and ask if the client agrees or disagrees. For example:

LTCS reads statement: "I have enough time to attend medical appointments."

Newly diagnosed client responds: "I have never attended a medical appointment."

LTCS asks client: "If you think about your schedule right now, do you believe you would have time to attend medical visits on weekdays when the clinic is open."

Newly diagnosed client responds: "No, because I work and it is very difficult for me to get time off."

LTCS marks that client "disagrees" with the statement on the survey form.

6. There are three statements on the survey that allow the client to choose "Not applicable" as their answer:
 - a. "I am able to find child care during medical appointment times". Only clients who are not responsible for children should answer "Not applicable."
 - b. "I am satisfied with my HIV medical provider". Only clients who have never met with an HIV medical provider should answer "Not applicable."
 - c. "I consistently remember my medical appointments". Only clients who have never had the opportunity to attend a medical appointment should answer "Not applicable."
7. Clients may choose not to provide answers to some or all of the statements listed on the survey. If the client refuses to answer, the LTCS should mark an "R" next to that statement.

The purpose of the Linkage to Care Program is to help you actively engage in HIV medical care. This survey is being used to assess the barriers and assets that may play a role in your ability to access HIV care. I hope to use this information to better serve you and your needs. All answers are confidential.

Please mark whether you agree or disagree with the following statements:

I understand how to make medical appointments.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I have reliable transportation.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I have enough time to attend medical appointments.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I have a stable living situation.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I am able to find providers and/or translators who speak the same language as me.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I have health insurance.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I am able to afford my medical expenses.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I am able to find child care during medical appointment times.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Not Applicable
Clinic times are convenient for me.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I am satisfied with my HIV medical provider.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Not Applicable
I am afraid other people will find out that I have HIV if I seek care.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I am worried about the types of questions (sexual practices, drug use, etc.) that will be asked during medical visits.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I don't want to be reminded that I have HIV.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I feel healthy; therefore, I do not need to seek HIV care.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I do not trust the medical system.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I think taking HIV medication will make me feel worse.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I believe that my HIV will be healed though my faith.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I prefer to use natural and holistic treatments.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I consistently remember my medical appointments.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Not Applicable
I am concerned about my use of drugs or alcohol.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
Sometimes I feel depressed, anxious or have other mental health concerns.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	
I have felt discriminated against when seeking care.	<input type="checkbox"/> Agree	<input type="checkbox"/> Disagree	

APPENDIX D: Case Management Comprehensive Assessment

CASE MANAGEMENT COMPREHENSIVE ASSESSMENT

This form is issued under 252.12 (2) 8, Wi. Stats. Personally identifiable information is collected to assist case managers in planning and coordinating services for persons with HIV infection (and will be used only for that purpose). Disclosure of social security number is voluntary and it will be used to assist the client in obtaining various federal, state and local entitlements.

ASSIGNED CASE MANAGER: _____ **File #:** _____

Intake Date: ____/____/____ Assessment Date: ____/____/____ Assign Date: ____/____/____

CLIENT CONTACT INFORMATION

Name:		Date of initial contact:	
Preferred Name/Nickname/Alias:			
Address:		County:	
City/Township:	State:	Zip Code:	
Phone (Home) () -	(Work) () -	<input type="checkbox"/> Message ok?	
E-mail Address:	DOB: ____/____/____	Sex: (circle one) M F T UNK	
Race:			
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Asian
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> More than one race	<input type="checkbox"/> Not reported	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Primary Language: _____		
Emergency contact:		Relationship:	
Address:	City:	State:	Zip Code:
Phone (H) () -	(W) () -	(C) () -	<input type="checkbox"/> Message ok?
Identify how emergency person should be contacted:			
Is emergency contact aware of client's HIV status? <input type="checkbox"/> YES <input type="checkbox"/> NO			

HIV STATUS INFORMATION

HIV Test Date: ____/____/____	AIDS Diagnosis Date: ____/____/____
Result: <input type="checkbox"/> HIV Positive, not AIDS <input type="checkbox"/> HIV Positive, AIDS status unknown <input type="checkbox"/> CDC defined AIDS	
<input type="checkbox"/> HIV indeterminate (under 2 years) <input type="checkbox"/> HIV Negative (not eligible for CM services)	
Proof of Status Requested* <input type="checkbox"/>	

**Proof of status must be received within 30 days of intake in order to continue receiving services.*

Is client receiving social or healthcare services from any other ASO/CBO? YES NO

If YES, please list sources and services:

HEALTH INSURANCE INFORMATION

Does the client have medical insurance coverage? YES NO

If YES, is the insurance coverage adequate? YES NO
(no significant gaps in coverage or unfunded services)

If NO, is client receiving necessary medical services? YES NO
 Explain: _____

Primary Health Insurance *(Attach coverage/co-pay information to assessment form and copy of card in file)*

Carrier	Policy/Group Number(s)	Effective Dates	Contact Info
<input type="checkbox"/> Private Insurance: _____ <i>(e.g. HIRSP, BCBS, etc.)</i>			() _____ - _____
<input type="checkbox"/> COBRA			() _____ - _____
<input type="checkbox"/> Medicare (T18)* <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D			() _____ - _____
<input type="checkbox"/> Medicaid (T19)* Plan _____			() _____ - _____
<input type="checkbox"/> Other Public*: List _____			() _____ - _____

**If client is not currently enrolled in these programs, was eligibility verified utilizing online ACCESS tool?* YES NO

Does the client have any secondary or other relevant coverage (*dental, vision, etc.*)? YES NO
 If YES, please list: _____

Is client eligible for coverage through the AIDS Drug Reimbursement Program (ADAP)? YES NO
 If YES, is client currently participating in ADAP? YES NO

Is client eligible for coverage through the Health Insurance Premium Subsidy Program (HIPSP)? YES NO
 If YES, is client currently participating in the HIPSP? YES NO

MEDICAL CARE AND ADHERENCE

Is client currently enrolled in primary medical care? YES NO

Primary Care Provider (PCP)

Name: _____ Phone: () _____ - _____ Fax: () _____ - _____

Type of Physician: (i.e. Infectious Disease, etc.): _____

Address: _____

Hospital/Clinic Affiliation: _____

Date of last medical visit: ____/____/____ Date of next medical visit: ____/____/____

Current CD4 count: _____ Date: ____/____/____
Current VL count: _____ Date: ____/____/____

Has client had any recent hospitalizations (within the past 90 days)? YES (Date: ____/____/____) NO
Explain: _____

Has client had the following diagnostic tests?

- Tuberculosis Date: ____/____/____ Result: _____
 Hepatitis C Date: ____/____/____ Result: _____

Has the client received the following vaccines?

- Hepatitis A Hepatitis B TWINRIX®

History of Opportunistic Infections? YES (please list) NO

Date: ____/____/____

Date: ____/____/____

Date: ____/____/____

Other medical conditions besides HIV (e.g. Heart Disease, Diabetes, Cancer, etc.)? YES (please list) NO

Dx. Date: ____/____/____ In care? YES NO

Dx. Date: ____/____/____ In care? YES NO

Dx. Date: ____/____/____ In care? YES NO

Has client been prescribed medications for their HIV or any other condition? YES (list name and dose) NO

From what pharmacy does client receive prescribed medication? _____
Pharmacy Phone: () _____ - _____ Fax: () _____ - _____

Treatment Adherence Screening

How frequently does the client miss scheduled medical appointments?
 Never Rarely Often Habitually

How frequently does the client miss scheduled doses of their HIV medications?
 Never 1 dose per week 2-3 doses per week 4-6 doses per week More than 6 doses per week

How often does client feel they have difficulty in taking their prescribed medication on time (Within 2 hours of scheduled dose)?
 Never Rarely Often Habitually

When was the last time the client missed at least one dose of their HIV medications?
 Never More than 2 weeks ago 1-2 weeks ago Within the past week

How does client feel about taking prescribed medications (HIV and other)? _____

Overall Health

In client's own words, how do they describe their current health? (e.g. Better/worse than 1 year ago; concerned about CD4/VL and/or medication regimen, symptoms, etc.)

Is client experiencing any barriers to accessing health care services? YES NO

Explain: _____

If heterosexual, does client have family planning in place? YES NO N/A

Women Only

Is client currently pregnant? YES NO

If yes, is client enrolled in pre-natal care? YES NO

Location: _____ Provider: _____

When was client's last vaginal PAP Smear? Date: ____/____/____ Normal Abnormal

Over 50, Has client had a recent mammogram (within the past 2 years)? YES NO N/A

Over 50, has client received any colorectal screenings? YES NO N/A

Men Only

When was client's last testicular exam? Date: ____/____/____ None on file

Over 50, has client received any colorectal screenings? YES NO N/A

Transgender Only

How does client identify? Male Female Neither Both

Has client had sex reassignment surgery (SRS)? YES NO

Is client on hormone replacement therapy (HRT)? YES NO

If YES, date started: ____/____/____

How does client access HRT? _____

Is PCP, aware of HRT treatment? YES NO

ORAL HEALTH CARE

Is client currently enrolled in oral health care? YES NO

Provider Name: _____ Phone: () _____ - _____ Fax: () _____ - _____

Address: _____

Hospital/Clinic Affiliation: _____

Date of last dental visit: ____/____/____ Date of next dental visit: ____/____/____

What is client's current oral health status? _____

Is client receiving recommended twice annual cleaning? YES NO

Is client experiencing any barriers to accessing dental services? YES NO

Explain: _____

MENTAL HEALTH

Is client currently enrolled in mental health services? YES NO

Provider Name: _____ Phone: () _____ - _____ Fax: () _____ - _____

Address: _____

Hospital/Clinic Affiliation: _____

Date of last visit: ____/____/____ Date of next Visit: ____/____/____ Frequency of visits: _____

Does client have a diagnosed mental health condition? YES NO List: _____

Has client ever received care (including hospitalizations) for a mental health condition in the past? YES NO
Explain: _____

Depression Screening (refer for professional assessment if total score is ≥ 3)

Over the past 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than ½ the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Anxiety Screening (refer for professional assessment if 2 or more are affirmative)

Do you often worry or feel nervous? YES NO

Are you often fearful of interacting with other people? YES NO

Do you ever feel jittery, short of breath, or like your heart is racing? YES NO

Do you ever feel as if you might lose control or fear that you may be "losing it"? YES NO

PTSD Screening (refer for professional assessment if 3 or more are affirmative)

Have you ever had any experience that was so upsetting, frightening, or horrible that you, in the past **month**:

Have nightmares about it or think about it when you do not want to? YES NO

Try hard not to think about it or go out of your way to avoid situations that remind you of it? YES NO

Are constantly on guard, watchful, or easily startled? YES NO

Feel numb or detached from others, activities, or your surroundings? YES NO

In client's own words, how do they describe their current mental health state? (e.g. *Better/worse than 1 year ago; concerned about behavior, symptoms, etc.*)

Suicide Screening

Has client ever had: suicidal thoughts? history of suicide attempts?

Does client have a specific plan for suicide? YES (immediate action required) NO

Has client ever been or expressed tendencies towards violent or abusive behavior? YES NO

Does client have access to lethal means (guns, etc)? YES NO

If YES, please describe _____

Does client have need for an immediate referral (e.g. suicide risk, etc.)? YES NO

SUBSTANCE ABUSE

Does the client have a history of or is he/she currently using/abusing substances? YES NO (skip section)

Is client currently engaged in substance abuse treatment? YES NO

What type? (check all that apply and explain level of engagement, frequency below)

- In-patient treatment
- Out-patient treatment
- Meetings, support groups, sponsor, etc.
- Other

Explain: _____

Types of substance use (check all that apply)

Substance	Frequency of Use	Route of Administration	Date of Last Use
<input type="checkbox"/> Nicotine		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Alcohol*		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Marijuana		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Cocaine		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Heroin		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Hallucinogens		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Crystal Meth		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____
<input type="checkbox"/> Other:		<input type="checkbox"/> Ingest <input type="checkbox"/> Inhale <input type="checkbox"/> Inject	____/____/____

CAGE-AID Screening (to identify substance dependence)

(A professional AODA referral and screening should be performed if score ≥ 2)

1. Have you ever felt the need to *cut down* on your use of alcohol or drugs? YES NO
2. Has anyone *annoyed* you by criticizing your use of alcohol or drugs? YES NO
3. Have you ever felt *guilty* because of something you've done while drinking or using drugs? YES NO
4. Have you ever taken a drink or used drugs to steady your nerves or to get over of a hangover (*eye-opener*)? YES NO

Is client on any prescribed medications for substance dependence? (e.g. Methadone, etc.) YES NO

(If yes, list in the above medications table)

If client is actively using, are they employing any harm reduction techniques? YES NO

Describe: _____

For clients in recovery:

How does client describe their progress? (completely clean, occasional relapse, length of sobriety, etc.) _____

What support or tools have helped client to remain clean? _____

Is client aware of their relapse triggers? If so, what are they? _____

Does client have need for an immediate referral (danger to him/herself or others)? YES NO

RISK ASSESSMENT

Indicate type of risk client is involved with?

Check all that apply: Sexual Needle Sharing Hormone Therapy
 Pregnancy/Breastfeeding (♀) Client is not engaging in any risk behaviors (**skip section**)

Does the client have a main partner? YES NO If yes, how long? _____
If YES, is the partner aware of the client's HIV status? YES NO

Does client have additional partners? YES NO
If YES, does the client discuss his/her HIV status with partners? YES NO
If YES, does the client ask partners about their HIV status? YES NO

Is client currently engaged in sexual activity? YES (indicated type below) NO
Check all that apply: Same sex Opposite sex Transgender Vaginal Anal Oral

Number of sexual partners in the past year? None 1 2-3 4-10 10+

Does the client use risk reduction strategies with main partner? YES NO

Does the client use risk reduction strategies with other partner(s)? YES NO

Does the client currently have any sexually transmitted infections besides HIV? YES NO
List: _____

If YES, is client receiving treatment for their STI's? YES NO

Is client currently engaged in needle or equipment sharing for drug/hormone injection? YES NO
How often? Daily Every Week Few times a month Seldom

Is client engaged in any risk reduction behaviors? YES NO
Check all that apply: Abstinence Monogamous relationship Needle Exchange/Cleaning
 Lower-risk sexual activity (oral sex, no fluid exchange, etc.) Condoms (♂/♀) Other: _____

Partner Services (PS)

Has client shared their HIV status with *all* sexual/needle sharing partners? YES NO

Has client discussed HIV testing with *all* sexual/needle sharing partners? YES NO

Is client aware of Partner Services (PS) available for partner notification? YES NO

Has client participated in PS? YES NO Referral to PS? YES NO

NUTRITION

How many meals is client eating during the day? _____

Types of food: (e.g. Fast food, home cooked meals, etc.) _____

Is client taking supplements? (e.g. Ensure, vitamins, etc.) YES (*list:* _____) NO

Has client experienced a significant weight change recently? (observed or reported) YES NO
Explain: _____

Does client require/desire a referral to a nutritionist? YES NO

VISION CARE

Is client receiving on-going optical care? YES NO

Provider Name: _____ Phone: () _____-_____ Fax: () _____-_____

Address: _____

Hospital/Clinic Affiliation: _____

Date of last visit: ____/____/____ Date of next visit: ____/____/____

Is client experiencing any barriers to accessing optical services? YES NO

Explain: _____

If client CD4<200, client is at risk for HIV related vision problems (e.g. CMV retinitis) and should receive appropriate screening.

ALTERNATIVE THERAPIES

Is client accessing any alternative/complementary therapies? YES NO
(e.g. acupuncture, herbal remedies, etc.)

Explain: _____

Does PCP/ID Specialist know about alternative/complementary therapies? YES NO

PRACTICAL NEEDS and SOCIAL SUPPORT

Housing

Client: (Check all that apply)

- Owns Rents (with valid lease in client's name) Lives in transitional/supportive Living Lives alone
 Lives with others Is unstably housed (living with friends, in shelters) Is homeless (How long: ____)

How many times has client moved in the past 5 years? _____

If client has moved more than 3 times in 5 years, explain: _____

In the past 12 months, has client had any trouble making rent or mortgage payments? YES NO

Does client need housing assistance? YES NO

Explain: _____

Has case manager conducted a home visit? (optional) YES NO

Activities of Daily Living (ADL)

Does client need assistance with any of the following? Patient is independent

Check all that apply:

<input type="checkbox"/> Bathing	<input type="checkbox"/> Dressing	<input type="checkbox"/> Exercise	<input type="checkbox"/> Writing letters/e-mails
<input type="checkbox"/> Grooming	<input type="checkbox"/> Yard work	<input type="checkbox"/> Cooking	<input type="checkbox"/> Shopping
<input type="checkbox"/> Dental care	<input type="checkbox"/> Home maintenance	<input type="checkbox"/> Feeding self	<input type="checkbox"/> Reading correspondence
<input type="checkbox"/> Walking	<input type="checkbox"/> Using telephone	<input type="checkbox"/> Housework	<input type="checkbox"/> Other:

Does client require the use of assistant devices? (e.g. walker, wheel chair, etc.) YES NO

Describe: _____

Is client currently receiving any home care services? YES NO

Describe: _____

Transportation

Does client have a valid driver's license? YES NO

Does client have access to regular mode of transportation? YES NO

What type? (check all that apply)

Personal vehicle Friend/Support person's vehicle Taxi Bus/public transportation

Does client need transportation assistance? YES NO

Social Support

Name of current partner/spouse: _____ N/A

Is partner/spouse aware of client's HIV status? YES NO

Domestic Violence Screening

The following questions should be posed to the client regarding their partner/spouse (if applicable):

1. Has your partner/spouse ever hit you or physically hurt you? YES NO

2. Had your partner ever threatened to hurt you or someone close to you? YES NO

3. Do you feel controlled by your partner or feel you are in danger? YES NO

4. Has your partner ever forced you to have sex when you didn't want to? YES NO

5. Has your partner ever refused to practice safe sex? YES NO

Does client have any other family members or friends whom they identify as support persons? YES NO

List:	Name	Relationship	Aware of Status?
	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

Does client have any other support system in place? (e.g. church, pets, clubs, etc.) YES NO

Describe: _____

Dependants

Does client have any minor children under the age of 21 or whose care they are responsible for? YES NO

If Yes, List:

Name	Age	Sex	Aware of Client's HIV Status?	Child's HIV Status	Aware of Own HIV Status?
_____	_____	M/F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	M/F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	M/F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	M/F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> UNK	<input type="checkbox"/> YES <input type="checkbox"/> NO

Does client need any assistance with child care or with notifying children of HIV status? YES NO

EMPLOYMENT AND EDUCATION INFORMATION

Employer: _____ Phone: () _____ - _____

Address: _____

Type of Employment: _____

Length of Employment: _____ Hours/week: _____ OK to contact at work? YES NO

Unemployed Reason: _____

Is client disabled? YES NO

If YES, has client applied for disability insurance? YES NO

If client is unemployed what is their perception of his or her ability to work? _____

Seeking employment? YES NO Referral requested/offered? YES NO

Is client literate? YES (In what language(s)? _____) NO

Highest level of education completed:

- Some High School High School 2 year college/Technical training 4 year college Graduate

Degree/Training: _____

Currently in school? YES NO

If YES, where? _____ Expected degree or outcome: _____

Future plans: _____

LEGAL ASSESSMENT

Is the client currently incarcerated? YES NO

Has the client ever been incarcerated? YES NO

If YES, what was the nature of incarceration? _____

Dates of incarceration: ____/____/____ TO ____/____/____

____/____/____ TO ____/____/____

Is client currently on parole? YES NO

If YES, until when? ____/____/____

Name of Parole Officer (PO): _____ Phone: () _____ - _____

Is it ok to contact parole officer? YES NO

Does client have any outstanding warrants/summons/cases pending? YES NO

If YES, explain: _____

Does client have any other pending legal needs? (e.g. Divorce, immigration, etc.) YES NO

If YES, explain: _____

Does client have any of the following in place?

Check all that apply:

- Power of Attorney Health Care Proxy Permanency Planning
- Standby Guardianship Living Will Last Will and Testament

FINANCIAL INFORMATION

Source of Income	Amount (/month)	App. Date	Effect. Date	Notes
Employment	\$			
Unemployment	\$			
SSDI	\$			
SSI	\$			
SSI-E	\$			
Temporary Assistance for Needy Families (TANF)	\$			
GA	\$			
Food Stamps	\$			
VA	\$			
Pension	\$			
Workman's Comp	\$			
Energy Assistance	\$			
Housing Assistance	\$			
Other* (specify)	\$			
Total Monthly Income	\$			

**If client has unreported ("under the table") resources, it must be included in the above worksheet and the client should be informed that the income must be reported to the IRS.*

Has Client submitted proof of income (POI)? YES NO

**Client has 30 days to submit POI in order to continue to be eligible for services.*

Comments:

EXPENSES WORKSHEET

Liquid Assets		Expenses (per month)	
	Cash on Hand		Food cost/month
	Checking Account		Insurance (life/health/car)
	Savings Account		Alimony/Child Support
	Stocks/Bonds		Mortgage/Rent
	Certificates		Utilities (gas/electric/other)
	Alimony/Child Support		Phone
	Cash Value of Life Ins.		Loans
	Other		Credit Card 1 payment/month
	Other		Credit Card 2 payment/month
	Other		Credit Card 3 payment/month
	Other		Other
	Total		Total

Monthly Income

\$

Monthly Expenses

\$

Expendable Income

\$

Household Members

NAME	RELATIONSHIP	GENDER	AGE/DOB

TOTAL HOUSEHOLD SIZE:

Federal Poverty Level: <100% 101-199% 200-300% >300%

ASSESSMENT REVIEW

I, _____ certify that the preceding assessment is an accurate reflection of my
CLIENT NAME
current health and social status. I actively participated in the assessment process and hereby agree to
enroll in case management services and overall coordination of my care.

CLIENT SIGNATURE Date: ____/____/____

SIGNATURE OF AUTHORIZED REPRESENTATIVE Date: ____/____/____

PRINTED NAME OF CASE MANAGER

SIGNATURE OF CASE MANAGER Date: ____/____/____

Signature below indicates that supervisor has reviewed all of the assessment documents and supporting materials and attests to the quality of the assessment.

PRINTED NAME OF SUPERVISOR

SIGNATURE OF SUPERVISOR Date: ____/____/____

Supervisor Comments:

APPENDIX E: Linkage to Care Service Plan

INSTRUCTIONS: Linkage to Care Service Plan

Field	Instruction
Date	Enter date of service plan creation
Client’s Goal for Transition	Circle either “case management” or “self-management” for client’s transition goal. This must be discussed with the client and determined at the time of service plan creation.
Goal Date for Transition	Enter the goal date for transition to either case management or self-management. <i>The goal date for transition should be no longer than 9 months from the date of initial intake in Linkage to Care services.</i>
Linkage to Care Specialist	Enter the name of linkage to care specialist/author of service plan.
Client	Enter the name of the client.
Client ID	Enter agency specified unique identification number for client.
Goal(s)	The goal for all Linkage to Care Service Plans is for the patient to be actively engaged and established in medical care. This goal is already listed on the service plan template.
Barriers to Engaging in Medical Care	List barriers identified by the client and/or linkage to care specialist that are keeping the client from achieving the goal of active engagement and establishment in HIV medical care.
Action Steps	List the steps both client, linkage to care specialist, and case manager (if applicable) will take in order to overcome listed barriers to medical care and achieve the goal. Statements should be very specific and linkage to care specialist should list as many steps as necessary to overcome each listed barrier (e.g. 1. Complete housing application, 2. Enroll in ADAP, 3. Refer to mental health treatment).
Responsibility	Indicate who is responsible for each action step by writing the responsible party next to the number associated with each action step (e.g. 1. Linkage to care specialist, 2. Case manager, 3. client). Responsibility for completing tasks must be shared between LTCS and client.
Dates	Indicate the start and end dates associated with each action step. The start date is the date that the action step is created. The end date is the estimated date that the action step will be completed. <i>The end date must be before the Goal Date for Transition.</i>
Status	Review the status of each action step on the end date listed. Document the status of the action step as “in progress”, “complete” or “incomplete”. If the status is “in progress”, create a new estimated end date and review status again at that time. If the status is “incomplete” and progress is not being made on the action step, provide brief explanation and revised estimated end date if appropriate (e.g. Client no longer wants to complete action step at this time, Client does not want to complete action step until AODA treatment is completed is 2 months).
Notes	Include any additional comments from either the linkage to care specialist or client in the space provided.
Signatures	Client and linkage to care specialist must sign in the appropriate place to indicate a mutual agreement on the service plan.

LINKAGE TO CARE SERVICE PLAN

Date:

Client's goal is to transition to (circle one):

Case Management

Self-Management

Goal Date for Transition:

Linkage to Care Specialist:

Client:

Client ID:

Goal: Client is actively engaged and established in HIV medical care.

Barrier(s) to engaging in HIV medical care	Action Steps	Responsibility	Start Date	End Date	Status

--	--	--	--	--	--

Notes

I have read, understand and agree with the above service plan.

Client or Guardian: _____ Date: _____ Linkage to Care Supervisor: _____ Date: _____
SIGNATURE SIGNATURE

Linkage to Care Specialist: _____ Date: _____

APPENDIX F: Linkage to Care Daily Encounter Form

Every Friday please mail or email completed Daily Encounter Forms from the previous week to
Franela Ngaboh-Smart at:

Attn: Franela Ngaboh-Smart
Division of Public Health
1 West Wilson Street, Rm 265
Madison, WI 53701

Use the following instructions to complete Daily Encounter Forms.

Field	Instructions	Notes
Client ID	Enter the agency-specific client ID.	
Date of Service (DOS)	Enter the date the encounter occurred.	
Place of Service (POS)	Enter the place where the encounter occurred using the following codes: Inpatient (I) Clinic (C) Office (Off) Home (H) Other (O)	1. Use the Clinic code when the encounter is tied to a clinic visit with a medical or mental health provider. If an LTCS has an office in a clinic-based setting and the clients is coming in to meet with only the LTCS (ie. does not have a medical appointment) use the Office code for place of service.
Type of Contact	Enter the type of contact used using the following codes: Face-to-Face (FF) Collateral Face-to-Face (CFF) Phone Call (PC) Collateral Phone Call (CPC) Text Message (SMS) Collateral Text Message (CSMS) Email (EM) Collateral Email (CEM) Postal Mail (PM) Collateral Postal Mail (CPM) Client Fax (F) Collateral Fax (CF) Administrative/Paperwork (AP)	1. The Administrative/Paperwork type of contact should be used only for activities of 30 minutes or greater that are considered a service to the client but are not conducted in the presence of a client (for example, completing forms, researching housing or job opportunities).
If phone call, was client reached?	If the contact used is listed as PC, use the following codes to indicate whether the client was reached: Yes (Y) No (N)	
Total Minutes	Enter the total number of minutes it took to complete the encounter. Round to the nearest whole minute.	

For each encounter check the boxes that most closely correspond to the content discussed during that encounter. Definitions of each content field are provided in the table below.

Field	Definition
Attend HIV Medical Appointment	LTCS attend HIV medical appointment WITH client. LTCS may meet client at appointment or provide transportation to appointment.
Transport to HIV Medical Appointment	LTCS provides client with transportation to and/or from HIV medical appointment.
HIV Medical	<p>Encounters addressing client’s medical needs related to HIV. (Attendance or transportation to HIV medical appointments should be documented in the previous fields).</p> <p>Specific activities include but are not limited to; HIV education, risk reduction counseling, treatment adherence, scheduling HIV medical appointments, preparing clients for HIV medical appointments or labs.</p>
Mental Health	<p>Encounters addressing the client’s mental health needs.</p> <p>Specific activities include but are not limited to; screening clients for mental health issues, facilitating referrals to mental health treatment, counseling or support groups.</p>
AODA	<p>Encounters addressing the client’s AODA needs.</p> <p>Specific activities include but are not limited to; screening clients for AODA issues (SBIRT), facilitating referrals to AODA treatment</p>
Housing	<p>Encounters addressing the client’s housing needs.</p> <p>Specific activities include but are not limited to; assisting clients with housing applications, facilitating referrals to housing case management or other housing specialists, attending housing appointments with clients, assisting clients in obtaining rental assistance.</p>
Financial/Income	<p>Encounters addressing the client’s financial needs related to income.</p> <p>Specific activities include but are not limited to; assisting clients apply for programs to help cover costs of living expenses such as FoodShare or Energy Assistance (Rental assistance should be documented in the Housing field), facilitating client usage of Food Pantry services, assisting clients apply for programs that provide or supplement income such as Social Security, W-2 or private disability, facilitating referrals for assistance securing employment.</p>

Benefits/Insurance	<p>Encounters addressing the client’s needs related to coverage for medical services and prescription drugs.</p> <p>Specific activities include but are not limited to; benefits and eligibility screening, assisting clients apply for government programs such as Medicaid, BadgerCare and Medicare, assisting clients apply for private insurance such as HIRSP or employer-sponsored coverage, assisting clients apply for ADAP or other drug assistance programs.</p>
Transportation	<p>LTCS provides transportation to and/or from appointments other than HIV medical appointments.</p>
Emotional Support	<p>Encounters in which the LTCS is providing emotional support to the client. Emotional support includes expressions of care or concern, conversations to elevate the client's mood and/or improve the client's feelings of competence, belonging and esteem.</p>

APPENDIX G: Linkage to Care Transition Plan

Instructions: Linkage to Care Transition Plan

- Enter date, client name and LTCS name.
- Check service level that client will transition to after LTC discharge and list name of agency and provider (if applicable). More than one box may be checked if client will be working with both a medical and non-medical case manager after LTC discharge.
- For each “Indicated Need/Barrier” summarize the issues that have been resolved during the client’s enrollment in LTC services in the “Resolved” column.
- For each “Indicated Need/Barrier” summarize the issues that will still require action after the client’s discharge from LTC in the “Unresolved” column.
- Enter the individual responsible for taking action on any unresolved issues in the “Responsibility” column.
- Client, LTC specialist, LTC supervisor and case manager (if applicable) sign to indicate approval of Transition Plan prior to discharge from LTC services.

LINKAGE TO CARE TRANSITION PLAN

Date:	Client:	LTC Specialist:
-------	---------	-----------------

Transition to: Self-Management Medical Case Management Name: _____ Agency: _____
 Brief Services Agency: _____ Non-Medical Case Management Name: _____ Agency: _____

Need/ Barrier	RESOLVED	UNRESOLVED	Responsibility
Clinical/ Medical			
Medication Adherence			
Mental Health			
AODA			
Insurance/ Benefits			
Housing			

Employment/ Financial			
Transportation			
Legal			
Cultural/ Linguistic			
HIV Education/ Prevention			
Other			

I have read, understand and agree with the above transition plan.

Client or guardian: _____ Date: __/__/__

LTC Specialist: _____ Date: __/__/__

LTC Supervisor: _____ Date: __/__/__

Case Manager(s): _____ Date: __/__/__

APPENDIX H: State Discharge Form

STATE DISCHARGE FORM

CLIENT ID:

LTC DISCHARGE INFORMATION

LTCS Name:

Discharge Date:

Discharge Reason:

- | | | |
|---|---|---|
| <input type="checkbox"/> Service Completion | <input type="checkbox"/> Client request | <input type="checkbox"/> Deceased/ Date of death: |
| <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Transferring to another LTCS | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> LTCS request | <input type="checkbox"/> Moved out of service area | |

Discharge Service Level (select all that apply):

- | | |
|--|--------------------------|
| <input type="checkbox"/> Self-Management/ Brief Services | |
| <input type="checkbox"/> LTCS (for transfers only) | |
| <input type="checkbox"/> Case Management | Name of case manager(s): |
| | Agency: |

CLIENT INFORMATION

Current Housing Status:

- | | | | |
|---|-----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Stable/Permanent | <input type="checkbox"/> Unstable | <input type="checkbox"/> Temporary | <input type="checkbox"/> Unknown |
|---|-----------------------------------|------------------------------------|----------------------------------|

Current Insurance Status (select all that apply):

- | | | | | | |
|---|-----------------------------------|-----------------------------------|--|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Private | <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicaid Medical Home | <input type="checkbox"/> No insurance | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (specify): | | | | | |

LTC Client Survey Completed

Mail copy of completed Discharge Form and Client Survey to:

Attn: Franella Ngaboh-Smart
Division of Public Health
1 West Wilson Street, Rm 265
Madison, WI 53701

LTCS MANUAL ATTACHMENT B: SAMPLE LINKAGE TO CARE SPECIALIST BROCHURE

Linkage to Care Services



Help Is Here

Getting regular medical care can be challenging when life gets in the way.

Linkage to Care can assist with:

- Medical & Dental care: *Prescriptions and Health Insurance coverage/concerns;*
- Support Services: *Housing; Food; Utilities; Employment & Legal Aid;*
- Applying for Benefits: *SSI/SSDI;*
- Transportation: *To and from medical appointments*

For Linkage to Care services, contact:

AIDS Resource Center of WI (ARCW): 414.xxx.xxxx

MLK Heritage Health Center/EIP Dept: 414.xxx.xxx

Outreach Community Health Centers: 414.xxx.xxx

16th St. Community Health Center: 414.xxx.xxx

AIDS Network [Madison area]: 608.xxx.xxxx

LTCS MANUAL ATTACHMENT C: LINKAGE TO CARE SPECIALIST PERFORMANCE PROFILE

REQUIREMENTS	
Performance Objectives	<ol style="list-style-type: none"> 1. Conduct case finding for assigned linkage to care priority cases. 2. Complete intake and other required screenings to identify potential barriers to care and treatment preferences. 3. Conduct in-depth harm reduction screening and counseling as needed. 4. Provide HIV disease & treatment education. 5. Facilitate and accompany clients to clinical appointments at the clinical location or with the provider of their choice. 6. In coordination with client and clinical facility create “retention to care action plan”. 7. Establish and facilitate relationship between client and the following parties: partner services, clinical staff, and medical case management staff for the purpose of supporting retention to care.
Enabling Objectives	<ol style="list-style-type: none"> 8. Ability to coordinate with the Wisconsin AIDS Drug Assistance Program 9. Ability to operate in the field the majority of the time, conducting case finding, home, and clinical visits. 10. Ability to be on call and establish new patient contact within 24 hours of referral. 11. Ability to operate on-site at public and private testing locations to initiate linkage to care services. 12. Ability to transport clients to and from clinical appointments and other locations for the purposes of care coordination. 13. Ability to ensure personal safety while engaging clients in the field. 14. Request and acquire informed consents for the purpose of care coordination. 15. Ensure linkage to initial clinical care appointment within 3 months of diagnosis or within 3 months of service initiation. 16. Fluency in computer software and database programs such as Microsoft office suite and web-based data systems. 17. Maintain access to client records within Partner Services Database while conducting field work through the use of provided electronic equipment. 18. Meticulously and accurately record and document required electronic data for the purposes of accountability and reporting.
Position Requirements	<ol style="list-style-type: none"> 19. Attend quarterly linkage to care training sessions hosted by the Wisconsin AIDS/HIV Program. 20. Field experience with HIV positive or other high-risk clients conducting screening, education, and/or other outreach-type services. 21. Previous field-based or professional experience with post-incarcerated populations 22. Ability to establish working relationships with local detention facilities, parole officers, and other Department of Corrections Staff. 23. Field experience of formalized training in treatment adherence counseling. 24. Ability to maintain flexible hours beyond traditional work hours (9am-5pm). 25. Well developed team skills. 26. Ability to work independently in the field. 27. Experience working in or working with individuals in the clinical setting. 28. Understanding of confidentiality concerns and statues related to HIV and ability to maintain client confidentiality in accordance with HIPAA and Wisconsin Law.
Cultural Expectations	<ol style="list-style-type: none"> 29. Professional. 30. Flexible. 31. Team oriented (in reference to other Linkage to Care Specialists)

LTCS MANUAL ATTACHMENT D: PRELIMINARY TRAINING ACTIVITIES CHECKLIST

Linkage to Care Specialists (LTCS)
Preliminary Activities Checklist

The following checklist of activities should be completed no later than the **June 25-26, 2012** LTCS Training. Once activities are completed by LTCS, the direct supervisor must sign-off and submit to the AIDS/HIV Program for review.

FORMAL TRAINING & MEETINGS	Linkage to Care Specialist Initials	Supervisor Initials
Agency-specific orientation & training		
<i>HIV: Basic Facts</i> online training module		
<i>HIV Epidemiology in Wisconsin</i> online training module		
Linkage to Care Specialists Meeting (May 16, 2012)		
SPNS Linkage to Care Learning Session (April 26-27, 2012)		
<i>New Case Manager Orientation & Training</i> (June 12, 2012)		
ACTIVITIES		
Job shadow HIV test counselor - Observe 5 pretest counseling sessions - Observe 1 post-testing counseling sessions for new diagnoses if possible (prioritize for LTCS serving acute populations)		
Job shadow HIV case manager - Observe 6 total CM/client interactions, including two for clients new to the agency (may or may not be a new diagnosis), at least 1 for acuity 2 clients, and 1 for acuity 3 clients, if possible		

Meet with Partner Services Representative (coordinated by AIDS/HIV Program)		
Meeting with Prison Discharge Liaison (coordinated by AIDS/HIV Program)		
Attend clinical site visits (coordinated by AIDS/HIV Program)		
Complete mini-audit of internal case files to assess retention needs and submit completed assessment and evaluation as indicated on the instructions (attached)		
Complete LTCS pre-work evaluation (to be administered by CAIR)		
Read the In+Care Campaign literature review (attached)		
Read Linkage to Care article by Gilman (attached)		
Read the Partner Services, CTR, and Non-Medical Case Management standards/protocols to better familiarize self with the positions and their roles and responsibilities		
Assume LTCS case load of <u>at least 2 but no more than 5</u> individuals resulting from 1) internal retention audits, 2) on-site HIV testing of newly identified positives, or 3) recently released individuals from the Department of Corrections (DOC).		

LTCS MANUAL ATTACHMENT E: LTCS TRAINING DESCRIPTIONS

Required Courses

HIV: Basic Facts

This online course provides an introduction to HIV/AIDS for practitioners beginning to work in the field of HIV services. It examines basic information about the virus, transmission, disease progression, epidemiology, prevention, and services. The course focuses on the socio-behavioral aspects of HIV infection rather than the biomedical aspects.

Objectives:

- Answer basic questions about HIV, HIV transmission, and disease progression.
- Describe evidence-based interventions to reduce risks of transmission, including HIV testing.
- Identify agencies and organizations providing prevention and care services.
- State facts about populations affected by HIV in Wisconsin.
- Describe populations at greatest risk for HIV transmission in Wisconsin.
- Discuss implications for prevention and care related to the HIV health disparities.

Audience: Staff and Managers of agencies funded by the Wisconsin AIDS/HIV Program or permission of instructor.

HIV Counseling Skills

HIV Counseling Skills is a two-day workshop that provides an introduction to counseling skills essential for effective HIV counseling in a variety of settings, including community-based organizations and other venues. Participants learn about the federal Centers for Disease Control and Prevention (CDC) counseling protocol and have opportunities to develop counseling skills in the context of HIV work. HIV Counseling Skills uses techniques similar to motivational interviewing.

Objectives:

- Describe and demonstrate fundamental counseling concepts and skills.
- Describe the Stages of Change model of behavior change.
- Describe and demonstrate in practice sessions the steps of the HIV prevention counseling protocol.
- Demonstrate barrier methods to reduce sexual risk transmission.

Audience: Staff and Managers of agencies funded by the Wisconsin AIDS/HIV Program or permission of instructor.

New Case Manager Orientation & Training

This training is designed for case managers who are new to services in Wisconsin and who are employed with a Ryan White or Life Care Service funded agency to provide case management services. The one-day workshop is designed to provide a comprehensive introduction into case management services in Wisconsin as well as requirements for providing Ryan White funded case management.

Objectives:

- Increase participant knowledge regarding the established Practice Standards and Administrative Guidelines for HIV-related Non-medical Case Management.
- Increase awareness of the types of case management support available to people living with HIV in Wisconsin.
- Increase understanding of community resources available to assist both case managers and clients.
- Increase knowledge regarding the Wisconsin ADAP and HIPSP.

Audience: Open only to individuals who are funded by the Wisconsin AIDS/HIV Program to provide Ryan White case management services.

Optional Courses

Wisconsin Benefit System for People Living with HIV/AIDS

This one-day workshop provides information on various topics related to financial and health care benefits for people living with HIV in Wisconsin.

Objectives:

- Increase awareness of available benefits for people living with HIV/AIDS in Wisconsin.
- Increase working knowledge of eligibility criteria and limitations for benefits programs.
- Increase understanding of application process and timelines for various benefits programs.

Audience: Individuals who are funded by the Wisconsin AIDS/HIV Program to provide case management and/or client benefits counseling.

Annual Case Managers Meeting

This meeting is open only to Ryan White and Life Care Services funded case managers. Linkage to Care Specialists funded by the WI AIDS/HIV Program are also invited to attend. The one day meeting is designed to provide case managers with relevant updates to service provision and training around issues relevant to the delivery of case management services. This meeting will focus on the implementation of newly developed statewide Medical Case Management Practice Standards.

Audience: Open only to individuals who are funded by the Wisconsin AIDS/HIV Program to provide Ryan White case management services or linkage to care services.

Screening, Brief Intervention, Referral, Treatment (SBIRT) Training

Screening, Brief Intervention, and Referral to Treatment (SBIRT) an evidence-based and cost-effective service for addressing client alcohol/drug involvement. The service begins with a standardized alcohol/drug screen. For clients who show positive results, a brief intervention is delivered. A referral to specialist treatment may be initiated, as needed. For Medicaid clients, SBIRT is a reimbursable service. However, to become eligible for billing/reimbursement, non-licensed staff are required to complete a 60-hour training.

The training has four parts:

- Pre-training readings and assignments. The assignments must be completed and turned in prior to the on-site training.
- Initial on-site training September 30, October 1 and 2, 2013.
- Delivery of services and complete tracking assignment. Weekly conference call to discuss challenges and successes with implementation.
- Final on-site training January 27, 28 and 29, 2014.
- Each non-licensed staff participant must have an accompanying licensed supervisor in attendance on January 29. The supervisor's role is also to support service implementation in-between the on-site trainings.

Objectives:

- Be able to administer, score, and accurately interpret an evidence-based screening instrument.
- Be able to deliver a protocol-driven brief intervention.
- Identify the practice elements of motivational interviewing and begin working toward proficient practice.
- Increase empathetic responses and listening skills.
- Be able to identify client need for specialist treatment and how to maximize entry into services.

Audience: Medical case managers, non-medical case managers, and prevention case managers at agencies funded by the Wisconsin AIDS/HIV Program.

Motivational Interviewing for Risk Reduction, Retention in Care and Adherence

Motivational Interviewing (MI) is a an evidence-based, patient-centered communication strategy used to help clients explore and resolve ambivalence in order to change unhealthy or problematic behaviors. This two-day training will explore how HIV prevention counselors and case managers can use MI in conversations with clients around risk reduction, retention in care and adherence to promote healthy behavior change.

Audience: Staff and Managers of agencies funded by the Wisconsin AIDS/HIV Program or permission of instructor.

Adopting Motivational Interviewing into Practice

Motivational Interviewing (MI) is a collaborative and person-centered, yet goal-oriented method for promoting positive behavior change across a range of settings, populations, and problems.

This is an adoption training, that is, participants already have an interest in MI, have decided to integrate MI into practice, and there is desire to continue learning this evidence-based practice to proficiency standards. MI training research shows that "one shot" trainings are insufficient to promote even basic proficiency of practice, therefore, the objectives of this training are partly geared for what occurs after training.

Objectives:

- Be able to identify MI as an evidence-based practice;
- Be able to identify the basic elements of practice;
- Begin initial skill building;
- Increase you readiness to adopt MI into practice; and
- Engage continued learning via participation in a peer learning group.

Audience: Staff of agencies funded by the Wisconsin AIDS/HIV Program.

The Affordable Care Act: Preparing for Open Enrollment

This one-day workshop (formly titled Wisconsin Benefit System for People Living with HIV/AIDS) provides information on various topics related to the Affordable Care Act (ACA) and its impact on individuals living with HIV in Wisconsin. The workshop is designed to prepare case managers and other staff at AIDS/HIV Program funded agencies to assist clients in determining their eligibility for insurance and accessing appropriate coverage through the Health Insurance Marketplace and/or the BadgerCare Program. Changes to the ADAP and Health Insurance Premium Subsidy Program due to ACA implementation will also be discussed.

Objectives:

- Increase awareness of health insurance options available through the Health Insurance Marketplace and the BadgerCare Program.
- Prepare case managers and other relevant staff to assist clients in accessing coverage through the Health Insurance Marketplace and the BadgerCare Program when open enrollment begins on 10/1/13.
- Increase awareness of changes made to the ADAP and Health Insurance Premium Subsidy Program as a result of ACA implementation.

Audience: Individuals who are funded by the Wisconsin AIDS/HIV Program to provide case management and/or client benefits counseling.