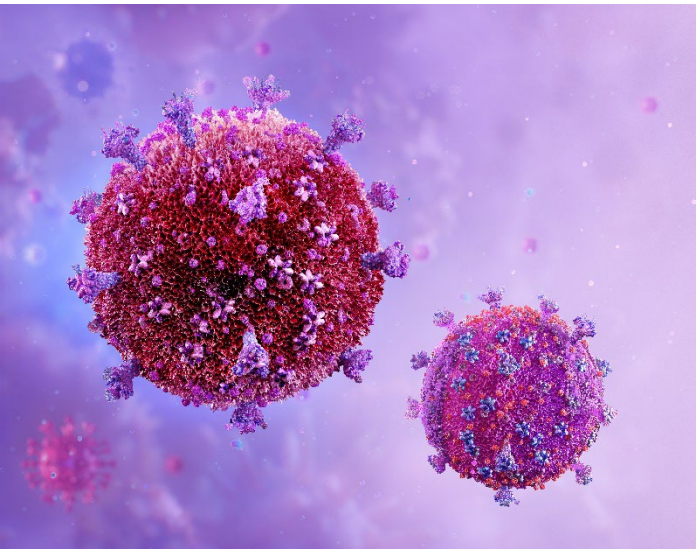


The Peer Navigator Program for People Living with HIV Manual

Wisconsin policies, procedures, and protocols

Wisconsin HIV Program
Division of Public Health, Wisconsin Department of Health Services

HIV Care Unit Contact Information

For information on:	Contact information
Peer navigation program funding, procedures, and reporting	dhsrwfeedback@dhs.wisconsin.gov
HIV case reporting Contact for HIV confidential case reports or to obtain HIV confidential case report forms	Phone: 608-266-2664 Fax: 608-266-1288 DHSHIVsurveillance@wisconsin.gov

Table of Contents

Common Acronyms

Ag/Ab – Antigen/antibody

AIDS – Acquired Immunodeficiency Syndrome

ARV – Antiretroviral

ASO – AIDS Service Organization

CBO – Community-based Organization

DHS – Department of Health Services

DPH – Division of Public Health

HDAP – HIV Drug Assistance Program

HIPAA – Health Insurance Portability and Accountability Act

HIV – Human Immunodeficiency Virus

MSM – Men who have sex with men

OI – Opportunistic infections

PHI – Protected health information

PLWH – People living with HIV

PS – Partner services

PNP – Peer Navigator Program

PN – Peer Navigator

PWID – People who inject drugs

SGL – Same gender loving

STD – Sexually transmitted diseases

SVL – Suppressed viral load

U=U – Undetectable equals untransmittable

Definition of Common Terms

Acute HIV infection: The time between when a person contracts HIV and when the person develops an antibody response. During the acute infection stage, the volume of the virus circulating in the person's bloodstream is very high.

Acquired Immunodeficiency Syndrome (AIDS): AIDS is the third stage of HIV infection and is the most severe on the body. People are diagnosed with AIDS when their CD4 cell (T-cell) count drops below 200 cells per micrometer or if they develop a certain opportunistic infection. As of this publication, using the term AIDS is discouraged. Instead, the most recent, accepted way to describe this stage is "stage 3 HIV."

Antibody: Proteins produced by the body to fight specific viruses.

Antigen: Proteins produced by the HIV virus that are detected during the early stages of HIV entering the body.

Health Insurance Portability and Accountability Act: Federal regulations requiring health care providers and organizations to protect and keep confidential protected health information when it is transferred, received, handled, or shared.

HIV: HIV stands for human immunodeficiency virus. HIV attacks the body's immune system, specifically the CD4 cells (T-cells), which help the immune system fight off infections.

Medication adherence: Taking HIV medications exactly as prescribed and every day.

Not engaged in care: Not having a CD4 cell (T-cell) count, viral load test result, or HIV-1 genotype completed in the last 15 months.

Peer: Someone who shares key characteristics such as race/ethnicity, language proficiency, sex/gender with the population they are serving. As it relates to the Peer Navigator Program for people living with HIV (PLWH), a peer is someone who is living with or impacted by HIV and works with PLWH.

Protected health information (PHI): Certain information about someone's health that is not allowed to be discussed to other people unless there is consent from the client/patient or it is allowed by law.

Opportunistic infection (OI): Certain infections or cancers that occur more frequently and are more severe in people with weakened immune systems, including people with HIV.

Recipient: The organization, agency, clinic, or health department receiving Ryan White Part B or Life Care and Early Intervention Care Services funding from the state of Wisconsin HIV Care Unit.

Retention: When someone living with HIV is linked to, engaged in, and remains in medical care.

Social determinants of health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

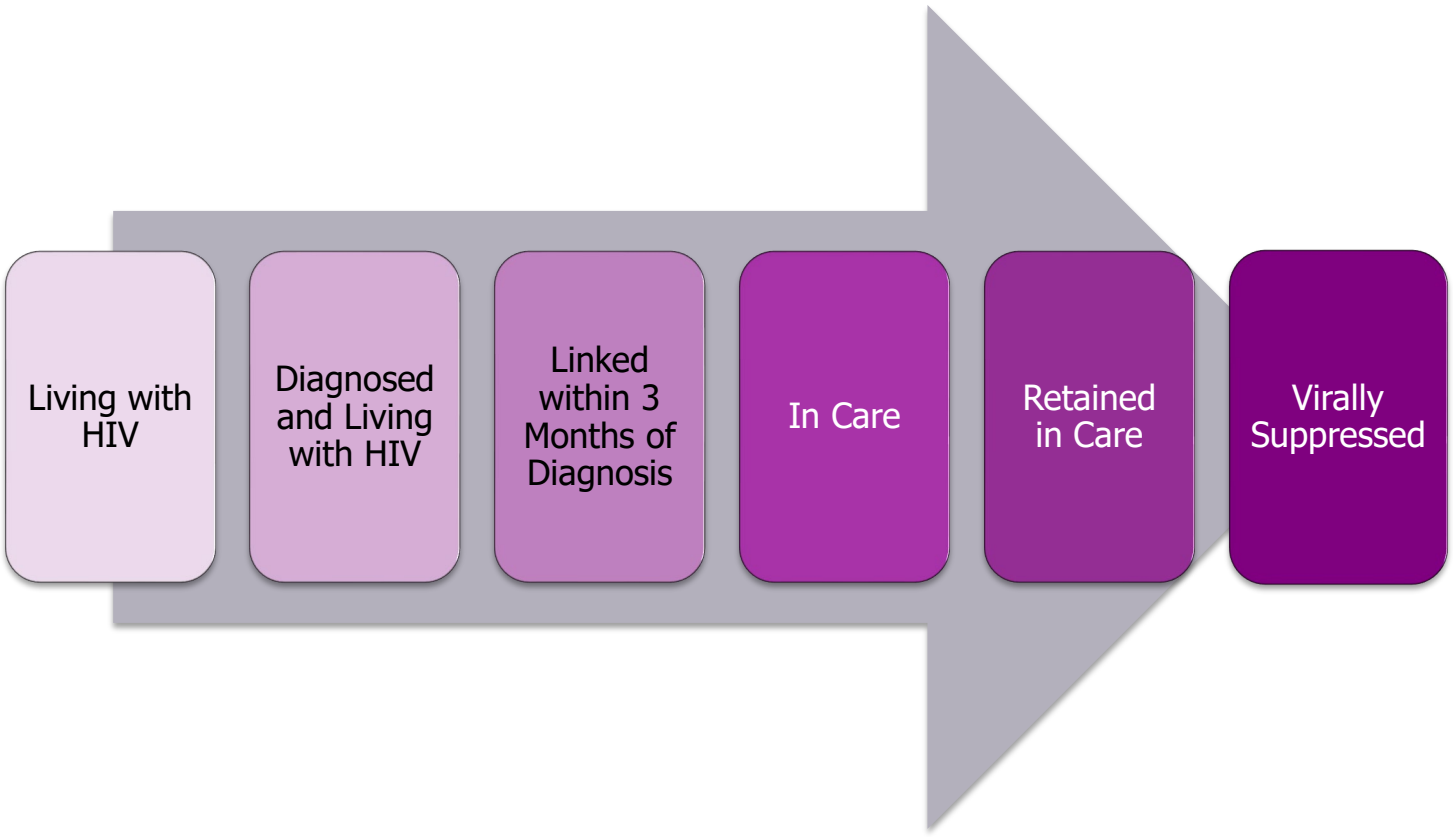
Treatment adherence: Includes starting HIV treatment, keeping all medical appointments, and rescheduling any missed appointments in a timely manner.

Undetectable: When HIV medicine makes the HIV viral load so low in the body that tests cannot detect it. This is often shown in labs as less than 20. This can only be checked through a blood draw.

Viral load suppression: When there are very low amounts of HIV virus in the blood (fewer than 200 copies of HIV per milliliter of blood) and keeps the immune system working and prevents illness. This can only be checked through a blood draw.

HIV Care Continuum

The HIV care continuum is a model that outlines the stages of HIV medical care a person goes through. Ensuring people living with HIV (PLWH) have the resources and support to actively engage in care and meet each stage of the continuum will improve their options to live the life they want. An individual must first know they are living with the HIV before they can receive adequate treatment and viral suppression. After diagnosis, there are programs, such as Peer Navigator Program, to support people with HIV in getting connected and engaged in care. Being in care is necessary to receive and adhere to effective antiretroviral (ARV) medication and ensure progress through every step of the HIV Care Continuum



Introduction and background

Intended audience for this manual

This manual is intended for recipient agencies funded by the Wisconsin Department of Health Services, Division of Public Health (DPH) HIV Care Unit, to provide peer navigation services. It is expected that all program staff, including peer navigators and their supervisor(s) remain knowledgeable of this manual and adhere to its recommendations, policies, procedures, and protocols.

Purpose of this manual

This manual was developed to:

- Provide a basic overview of the Wisconsin peer navigator program (PNP).
- Outline expectations and minimum requirements of the PNP.

Recipients funded for Early Intervention Service (EIS) peer navigation are required to adhere to the policies, procedures, and protocols outlined in this manual, in addition to the terms and conditions of contractual agreements, memoranda of understanding (MOUs), and data use agreements (DUAs) with the Wisconsin HIV Care Unit. This manual is not all encompassing but provides the **minimum** requirements for the program. It is expected that recipients implementing the PNP will exceed minimum requirements as appropriate to their capacity and the needs of their communities.

Purpose of the peer navigator program

The Wisconsin HIV Care Unit and its partners developed a public health intervention, known as the Peer Navigator Program (PNP) for People Living with HIV (PLWH), to reengage those who have been lost to care and are not virally suppressed. The program will identify PLWH who have been lost to care and will link them with a peer navigator to provide additional support to overcome systemic and emotional barriers to HIV treatment adherence and viral suppression.

Recipients funded to provide peer navigator services will offer the following critical services:

- Readily accessible HIV counseling, education, and referral services for individuals not engaged in HIV care services or struggling to overcome barriers to managing their HIV through traditional care services (for example, case management).
- Coordination of care assisting clients with scheduling appointments, reminding clients of appointments, and attending appointments with clients.
- Client-centered peer support designed to promote treatment adherence and viral suppression.
- Role modeling and behavior change counseling through self-efficacy, action planning, health management, and self-advocacy skills building and practice.
- Referrals for medical and social services resources and community resource navigation
- Support to existing care team and interdisciplinary team collaboration.

Target audience for peer navigator services

Peer navigator services are designed to serve populations who have been diagnosed with HIV and are not linked to, engaged in, or adhering to treatment and HIV care services and are not virally suppressed. The roles of the peer navigators are to support outcomes of the HIV care continuum.

Peer Navigator program eligibility

Participants eligible for peer navigator services must meet all the following criteria:

- Reside in Wisconsin.
- Been diagnosed with HIV.
- Need support to engage or remain engaged in care.

Depending on funding sources some PNP sites may have income restrictions. Please confirm your program's guidelines with your supervisor.

Ryan White Part B eligibility

To meet federal requirements, clients must also:

- Be living with HIV.
- Be uninsured or underinsured.
- Be income eligible based on the family income limit of 500% of the federal poverty level.
- Be residing in Wisconsin.

Life Care Early Intervention Services (LCEIS) eligibility

To meet state requirements for peer navigation, clients must also:

- Be living with HIV.
- Be residing in Wisconsin.
- Be uninsured or underinsured.

Peer navigator service goals

Program goals include:

- Decreasing barriers to achieving viral load suppression.
- Reducing HIV-related disparities and health inequities.
- Increasing provider awareness of the PNP.
- Increasing medication access and treatment adherence using HDAP.
- Increasing participant access to HDAP.
- Increasing and sharing knowledge of local community resources.

Peer navigators should work with clients to build the following skills and knowledge:

- Using self-advocacy in medical and social services settings.
- Understanding lab reports.
- Communicating effectively and efficiently with providers.

- Requesting and navigating community resources.
- Understanding basic HIV information, including the importance of treatment adherence and viral suppression.
- Using strategies to remember taking any prescribed medication and attending appointments.
- Removing barriers to managing their health.
- Navigating medical and insurance systems.

Service Requirements

Recipient requirements

To assure quality services and to meet state and federal standards, recipients must agree to meet the following core requirements:

Confidentiality and contracts

- Meet state requirements for confidentiality, informed consent for testing, and HIV case reporting.
- Be knowledgeable of and follow current state statutes (laws) related to HIV (Wis. Stat. ch. 252).
- Comply with Wisconsin HIV Care Unit's data collection, entry, and reporting requirements including mandated quarterly and annual reports.
- Have a physician, nurse practitioner, or physician assistant licensed in the state of Wisconsin with experience in HIV medical care provide medical oversight of PNP activities, including review and written approval of PNP recipient policies and procedures. This can be onsite if the program is housed within a clinic.
- Comply with all policies, procedures, and protocols outlined in this manual and any relevant standards of care.
    - Please contact your supervisor or Wisconsin HIV Care Unit staff if you are unclear which standards apply.

Referrals

- Coordinate with other local agencies to facilitate referrals related to HIV and sexually transmitted infection (STI) prevention and treatment, general health, daily living needs, mental health and social service needs.
- Coordinate services with other local agencies to facilitate referrals for clients who meet PNP eligibility to access peer navigator services, medical care, partner services, HIV case management or linkage to care, and other care services.
- Obtain MOUs with other local agencies, as needed.
- Maintain a list of community resources that is updated at lease annually.

Notes

Client documentation and notes are the responsibility of the peer navigator or any other personnel interacting with a client through the PNP. All documentation must be electronically entered into client record within three business days of the day of interaction. All documentation that details a crisis needing urgent response must be entered within 24 hours of the incident.

Documentation should be specific, detailed, concise, and understandable. Documentation should be written in a way that anyone who did not interact with the client would be able to understand when reading. Dates, times, location, and staff name(s) should always be included in any documentation.

Data entry and confidentiality

Ensuring confidentiality and security of client records is imperative for the integrity of the PNP. All release of information forms and any other consent forms must be documented and stored in the client's file.

Reports

Quarterly reports should be submitted to the Wisconsin HIV Care unit in the format provided. Due dates are as follows:

Time Period	Report Due
Jan. 1–Mar. 31	**April 30**
April 1–June 30	**July 31**
July 1–Sept.30	**Oct. 31**
Oct. 1–Dec. 31	**Jan. 31**

Staff training requirements

Wisconsin HIV program trainings

Peer navigators, including program managers, are required to attend the following Wisconsin HIV Program sponsored training.

HIV Basic Facts (online)

- HIV basic facts online training can be accessed at any time during the year. Staff should register for the training online and they will be approved to complete the online modules at their own pace.
- Submission of Certificate of Completion is required.

Hepatitis C Basic Facts (online)

- Hepatitis C Basic Facts online training can be accessed at any time during the year. Staff should register for the training online and they will be approved to complete the online modules at their own pace.
- Submission of certificate of completion is required.

Site specific training (in-person)

- Each site is responsible for developing a training program for peers.

- The program must include sections on assessment tools, documentation, eligibility policies and document collection and storing, crisis management, and any Wisconsin HIV Care Unit standards of care that apply.
- Participants are required to attend all sessions.
- Wisconsin HIV Care Unit staff are available to provide training and technical assistance to help sites comply with this expectation.

Motivational interviewing competency (in-person)

- The Wisconsin HIV Care Unit will identify opportunities for peers to get trained on motivational interviewing (MI) and share them with the recipient.
- Peer navigation staff are required to attend a complete training (all days, if multiple days) within their first year of service.
- If a peer navigator has had previous and recent MI training, they can request permission from the Wisconsin HIV Care Unit to forgo the state MI training with proper documentation that they have completed MI training elsewhere.
- Contact the Wisconsin HIV Care Unit services coordinator at DHS for registration or completion exception.

State sponsored training

- Peer navigation staff must attend periodic training sponsored by the Wisconsin HIV Care Unit.
- This includes but is not limited to the HIV Care services annual meeting, unless permission for absence from the HIV Care services annual meeting is granted by the Wisconsin HIV Care Unit.

Confidentiality requirements

Client confidentiality is vital to the success of the peer navigator program. Strict client confidentiality must be maintained to protect the client and to preserve the integrity of the peer navigator services. Client confidentiality is not limited to just protecting the client's name, but also applies to other information that could identify a client, such as where they reside, their age, race or ethnicity, or social connections.

The right of an individual to have personal, identifiable health information kept private must be protected and upheld. Program staff must be aware of the various ways that client confidentiality can be compromised, including in-person, on the phone, through email, texting, leaving a laptop open with unprotected client information on it, through social media, or inappropriate handling of hard copy documents. Staff may work off-site and interact with medical and social service providers on their client's behalf, which can increase the risk for breach of confidentiality of client protected information. Staff must take specific measures to ensure they maintain client confidentiality when working off-site.

- Confidential client information must be kept in locked file cabinets in a locked room.

- Paper client information must be transported in portable, locked file containers.
- Staff must ensure this information or any device with information on it is securely stored in the vehicle's locked trunk and not visible in the vehicle.
- All files should be returned to the recipient office at the end of the provider-client session, when possible.
- Files must not be left in motor vehicles overnight.
- Any device with client information on it must not be left in motor vehicles overnight.
- IDs or passwords must not be shared with anyone.
- Individual users should have individual login IDs and secure, individual passwords.
- Log off or lock any electronic devices when you're not using them or you step away from them, no matter how long you'll be away.
- Follow the minimum record retention rule of maintaining client records and fiscal records for at least six years after the end of the contract with the Wisconsin HIV Care Unit.
- Use secure shredder bins to dispose of documents containing confidential information.
- Maintain possession of mobile devices (for example laptops, smartphones, USB flash drives, tablets) that are used to store client documents, records, or client identifiable information.
- Ensure mobile devices that are used to store and transport client information are secure by enabling encryptions, firewalls, and secure user authentication on every device.
- Maintain a private, comfortable, nonthreatening environment that will foster open discussion and ensure confidentiality when meeting clients at the recipient site.
- Maintain a private environment that will foster open discussion and ensure confidentiality when meeting clients in the community (for example, reserved study room at local library or university, client's home when no-one is around).
- Limit access to client information and records to those with a legitimate need to access the documents (for example, supervisory oversight staff, and medical providers).
- Require all program staff to sign confidentiality agreements at time of hire, which should be maintained in their personnel files. Confidentiality agreements must be re-signed every 365 days.
- Review confidentiality policies and monitor recipient procedures every two years to ensure client confidentiality is maintained.

Peer navigators are often members of the same community as their clients and therefore may encounter their clients outside of work and in social settings. It is crucial that navigators uphold their clients' confidentiality during these times. At intake the client and navigator must discuss how this looks in practice and client preferences.

The peer navigator must never:

- Reveal the client's participation in the program to anyone without express consent from the client and proper documentation of informed consent.
- Acknowledge their client first. If the client acknowledges the peer navigator it is permissible to interact.

Clients and navigators may have preexisting relationships or may have mutual acquaintances. Every effort must be made to ensure that the peer navigator and the client are comfortable in their working relationship. Reassigning navigators may be necessary should the relationship boundaries become unclear or stressed. Peer navigators are prohibited from working with any individual with whom they have had or currently have a romantic or sexual relationship. The peer navigator may work with the client to identify a peer navigator who would best be suited for the professional relationship and then release all care responsibilities to that peer navigator. Any client relationship that prohibits a peer navigator from making unbiased, objective decisions must be avoided. Each recipient providing peer navigation services must have a policy in place to address such concerns and made available to each peer navigator.

Electronic communication

Electronic communication refers to text, email, social media, and any other form of communication done using electronic devices.

Risks of using electronic communication

Transmitting client information by electronic communications has several risks that clients and providers should consider before using it. These include, but are not limited to, the following:

- Emails and social media addresses/handles may be easily misread and therefore addressed to unintended recipients.
- Electronic communications may be circulated, stored electronically and on paper, forwarded, posted, shared, and broadcasted to unintended recipients.
- Backup copies of electronic communications may exist by digital media companies (for example, Google, Snapchat, Facebook) even after the sender or the recipient has deleted their copy.
- Electronic communications may be easier to falsify than handwritten or signed documents.
- Employers and online services have a right to inspect email transmitted through their systems.
- Electronic communications may be hacked or attacked by viruses, making the data exchanged vulnerable.
- Email and other electronic communications may be used in court.

Conditions for the use of electronic communication

Electronic communication may be preferred by the client and the peer navigator should honor such a request to the extent of following all policies and Wisconsin statues. Peer navigators should take extreme precautions to never disclose confidential information via electronic communication and to ensure the client is aware of the risks of receiving the electronic communications. Peer navigators must confirm their client's consent to such communications by signing the consent to follow-up form. Electronic communications are to follow these documentation standards:

- All electronic communications must be documented using a secure data system detailing the mode of communication (for example, text, social media, email), date, extent of the communication, and result of the communication.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) recommends that email that contains protected health information be encrypted.
- All electronic communications must never be altered, deleted, or edited to falsify information.
- Use emojis or other characters carefully when communicating with clients to limit misunderstandings. Document emojis and other characters in any notes pertaining to the interaction, when used. An explanation of the emoji or character meaning may need to be stated when documenting, when unclear.

When using electronic communications peer navigators must be aware of the following:

- Whenever possible an in-person meeting or phone call be scheduled when discussing sensitive information.
- Electronic communications should not be used to initiate conversations discussing sensitive or protected information such as, but not limited to, medical information, social security number, HIV/AIDS status and related medical information, mental health or substance use.
- Agencies are not liable for breaches of confidentiality caused by the client or any third party.
- All breaches or suspected breaches of confidentiality must be reported to the Wisconsin HIV Care Unit within the time described in Wisconsin statues.

Record keeping requirements

An electronic file must be established for each client receiving peer navigator services. Whenever possible these files should be in a confidential electronic filing system. These forms and documents are addition to, and support information collected in the electronic database used for documentation, assessments, and notes. The file should retain copies of all peer navigator program documents and data collection forms used as part of peer navigator services.

Any authorization for release of confidential information is only valid for one year from date signed. The authorization of confidential information must be explained to and re-signed by the client if the provider-client relationship exceeds one year. An authorization for release of confidential information must be completed for each care provider the peer navigator expects to communicate with or whomever their client wishes their peer navigator to communicate with when it pertains to exchanging confidential information. Termination or revisions of the authorization of confidential information can be made by the client at any time and the provider must adhere.

Quality assurance requirements

The purpose of a quality assurance program is to ensure that data is accurate, consistent, and timely.

Written quality assurance policies and procedures must be developed by the recipients providing Peer navigator services and be made available to all PNP staff and routinely implemented.

Quality assurance measures should ensure services and material are accessible and appropriate to the client's culture, language, gender, sexual orientation, age, developmental level, and risk activities. In addition, quality assurance measures should ensure all data is collected and entered in a timely manner following program requirements, collected, and entered in accurately and in the appropriate fields, reviewed routinely for accuracy, and are used appropriately for program goals and objectives.

Five characteristics of high-quality information include:

- Accuracy
- Completeness
- Consistency
- Uniqueness
- Timeliness

Site visits

The Wisconsin HIV Care Unit will conduct on-site programmatic monitoring visits at least annually or in accordance with a site visit waiver and recipient monitoring plan approved by HRSA. The visits will include reviews of:

- Fiscal systems, reports, and documentation including tracking and use of program income from third-party payers.
- Client-level data reporting systems.
- Client records for all funded services.
- Quality management and improvement activities.
- Compliance with relevant State and Federal guidelines.

Other services

Medical transportation assistance is the provision of non-emergency transportation services that enables PLWH, referred to here as client, to access or be retained in HIV-related core medical or support services. It is a service provided to the client to enable them to obtain a Ryan White funded service. Please refer to the Ryan White Part B Medical Transportation Policy for further information.

Primary transportation should be the most cost-effective method, when reasonable. Agencies are encouraged to pursue other options before enlisting cab or ride service (such as Lyft or Uber), if possible. There may be instances where a cab ride is the best transportation option due to the client's geographic location, physical or mental health, or urgency of the situation. If a recipient offers cab or ride services and other modes of transportation, the recipient should have an established policy that explains how the recipient determines which form of transportation assistance is used in different circumstances.

All medical transportations issued must be documented using a medical transportation log. Sites must create their own to be approved by the Wisconsin HIV Care Unit before use. An example log created by the Wisconsin HIV Care Unit is provided in this manual (Appendix D).

Staff transportation for the delivery of services

Transportation for staff that allows the staff person to complete their job duties is considered part of the service category for which that staff person is funded. For example, the mileage for a peer navigator to travel from their office location to meet a client at a public location is considered part of the peer navigation budget. This transportation must be tracked and logged separately from any transportation assistance provided to clients.

Recipients may reimburse staff for mileage for travel necessary to perform core work responsibilities, such as meeting a client at an appointment. All travel should be correlated with accurate documentation in the client record and verified by the program manager. The program manager has authorization to deny mileage reimbursement if proper documentation of travel is missing, inaccurate, or requires further information.

Each recipient has the authorization to develop their own mileage reimbursement procedures as long as it does not infringe upon program travel requirements and follows Wisconsin DHS policies.

Individual supervision

Individual supervision will take place for each peer navigator by a program manager and must be documented.

Follow-ups

Peer navigators must follow-up with the client regularly with frequency of interactions based on client's needs. At minimum, the peer navigator must check-in with the client once a month. In person interactions must be attempted or offered at least once a month. Any attempt to contact the client without success is considered interaction and should be treated like one. Peer navigators must document any client interaction and any attempt to contact the client. Even if a client does not answer the phone or is unable to be reached, details of the attempts and outcomes need to be documented.

Referrals

Immediate referrals, internal and external, to appropriate services are required for clients who:

- Are not engaged in medical care.
- Are taking medication but will run out prior to first medical appointment.
- Are a danger to themselves or others.
- Are under the age of 18.
- Are pregnant.

Referrals to the PNP may happen in three ways: external, internal, or walk-ins.

External

An external referral is when a client is referred to the PNP by an individual from another agency. A release of information is necessary if client information is being shared with another provider during the referral process. Developing community partnerships between organizations is vital to receiving external referrals to the program. See Appendix D for workflow.

Internal

Internal referrals happen when a staff member from the recipient housing peer navigators offers the PNP to a client. Internal referrals may be made by peer navigators themselves or by an HIV test counselor, programming leader, health educator, or other staff. Internal referrals do not always require a release of information to be signed to initiate the referral between internal staff. However, receiving verbal consent prior to making the referral is best practice. See Appendix E for workflow.

Walk-ins

Some individuals may hear of the program from flyers, brochures, or from their friends or family and decide to come into the recipient office directly to ask to participate in the PNP. It is important that the receptionist is aware of the program and the contact person to connect the individual with so they may learn more and determine eligibility. See Appendix E for workflow.

Documentation

Documentation of every type of referral and their results when known, must be included in the client record.

Program Staff Roles and Responsibilities

Peer navigators

Roles and responsibilities

- Engage with, refer, and link clients to services
- Address barriers to initiating services
- Coordinate with health and other social service providers as needed
- Promote treatment and medication adherence
- Transport and accompany clients to HIV-related appointments
- Provide emotional support
- Educate clients
- Inform clients about harm reduction practices

Competencies and skills

- Lived experience with HIV
- Ability to work with diverse groups
- Strong communication
- Advocate for self and others
- Trauma informed care

An overview of trauma informed care can be found on the DHS trauma informed care website. The website include webcasts and highlights the principles of trauma informed care as well as resources.

Program manager

The program manager should be an individual with social service background who is also knowledgeable about the scope of work and standards for the peer navigation program. The program manager or a person in an equivalent position is the primary supervisor of the peer navigators and the liaison between the Wisconsin HIV Care Unit and recipient. The program manager may also maintain a case load as other responsibilities allow.

Roles and responsibilities

Individual supervision

The program manager is required to have a minimum of one individual supervision meeting each week with each peer navigator. Individual supervision provides a private opportunity to address any concerns, questions, or issues the peer navigator or the program manager has. Frequency of individual supervision surpassing the required minimum is decided by the program manager. During individual supervision, the peer navigator's performance should be discussed—identifying strengths, limitations, and action steps to improve. Any disciplinary action or staff grievances identified during individual supervision should be documented and maintained in the appropriate personnel files.

Group check-ins

Monthly, the program manager will be responsible for scheduling group check-ins with all peer navigators. During group check-ins, program updates will be delivered, and program procedures will be reinforced, if necessary. At least 30 minutes of the time should be spent discussing a current peer navigator program case. The program manager will notify a peer navigator prior to the group check-in to present one of their client's cases. The peer navigator will informally present their case, actions taken, planned actions and goals, concerns, and any other areas for discussion to receive feedback on. This is an opportunity for all peer navigators to learn from each other through discussion and case reflection.

Ensure peer navigators meet performance standards and are adequately supported

The program manager is responsible for ensuring all program requirements are met by evaluating the performance of the peer navigators, meeting deadlines, reviewing case notes in their entirety, and making sure the workflow is effective. The program manager ensures the peer navigators are completing their tasks efficiently, effectively, and professionally. The program manager is responsible for mentoring and supporting their staff.

In addition to their own case load, the program manager will be available to all program participants. During the introduction to the program, participants will be informed how to reach the program manager if they cannot reach their assigned peer. This is to ensure clients are aware of the program manager's presence and support, should it be needed. Moreover, during days a peer navigator is absent, it is the responsibility of the program manager to assign a peer navigator to address the client's needs, if they arise.

Manage peer case loads

The caseload is the total number of clients a peer navigator is responsible for providing support to. The caseload should be determined based on:

- The total number of individuals currently in the care network.
- Distribution of high to low need individuals.
- The number of peer navigators available.
- Individual peer navigator capacity.

It is the responsibility of the program manager to assign, distribute, and evaluate the caseload. During individual supervision, the program manager may assess the peer navigator's capacity and performance based on their caseload. Though it is important that as many people who may benefit from peer navigator services have access to the service, the well-being of the peer navigator and the quality of care provided to clients should not be hindered by increasing the caseload. The program manager is responsible for identifying when it is appropriate to maintain a wait list of clients. Communicating expected timelines to referral sources is best practice.

It is recommended that an individual's caseload remain between 20–40 clients. At times this may not be realistic, therefore monitoring the case load is necessary. Part-time employees should not be

expected to have the same caseload as full-time employees. Additionally, not every client will require the same intensity of care and support. A peer navigator may only have 10 clients that require greater care due to more intense needs. Another peer navigator may have 30 clients who have less intense needs. Understanding client needs for each peer navigator is vital to reducing burnout and inadequate care.

Communicate with program coordinator

The program manager is the primary contact between the Wisconsin HIV Care Unit and the recipient. It is the responsibility of the program manager to provide the Wisconsin HIV Care Unit with deliverables, including but not limited to reports, data, forms, and performance reviews. The program manager is expected to complete regularly scheduled phone calls, emails, and meetings. The program manager must respond to all communication requests within 72 hours during regular business days. The program manager must follow all program policies, procedures, and protocols outlined by the Wisconsin HIV Care Unit and the recipient.

Data quality assurance

Ensuring that data is accurate and reliable is primarily the program manager's responsibility. The program manager must ensure that program staff understands the importance of data collection, data quality assurance, data security, and timely entry of data. For the first six months, the program manager will work with the Wisconsin HIV Care Unit to ensure quality assurance, specifically as it relates to managing the database in which the peer navigators' work will be documented. In the first year of funding the program manager will be responsible for submitting quarterly reports to the Wisconsin HIV Care Unit. Agencies must also follow quality assurance measures found in the Ryan White Part B Universal Standards as well as the Life Care and Early Intervention Services Universal Standards. Ask your supervisor which you will need to be familiar with.

Community involvement

During the first year of PNP implementation, the program manager will be responsible for ensuring space is allocated for community involvement. This could be in the form of consumer surveys, focus groups, or a Community Advisory Board (CAB). The Wisconsin HIV Care Unit is available for technical assistance with community involvement upon request.

Competencies and skills

The program manager will have experience and expertise in the following areas:

- Managing project budgets and requirements.
- Meeting program deadlines.
- Supervising and mentoring employees and preventing, mitigating, and solving employee issues to ensure high team morale, performance, and retention.
- Utilizing computer programs, particularly Microsoft Word, Microsoft Excel, and Microsoft Exchange.
- Utilizing electronic client record data bases or electronic medical records.
- Strong written and verbal communication.
- Data monitoring and quality assurance, data entry, analysis, and reporting.

- Working with diverse populations, particularly queer communities and communities of color.
- Making well-analyzed, appropriate, and problem-solving decisions.

Discharging Clients

Closing a case

Peer navigators will be responsible for reengaging clients who have been lost to care back into care and connected to services. Additionally, building confidence, identifying strategies, and increasing knowledge about how to successfully manage their HIV are also vital to the program. This approach empowers individuals to become their own advocates and ensures they remain in care long term. Identifying a process for graduating from the program will not only instill motivation, direction, and achievement, but will also ensure services are available to new clients. Reopening a case is permissible if program eligibility is reinstated or client contacts the peer navigator after three attempts have been made.

Graduation

Each organization must have an assessment tool that includes a scoring method by which client readiness for graduation can be measured. Graduation should take place when the assessment tool shows the client's readiness and ability to manage their own care by navigating health care systems and support services.

Any assessment tool used must be approved by the Wisconsin HIV Care Unit.

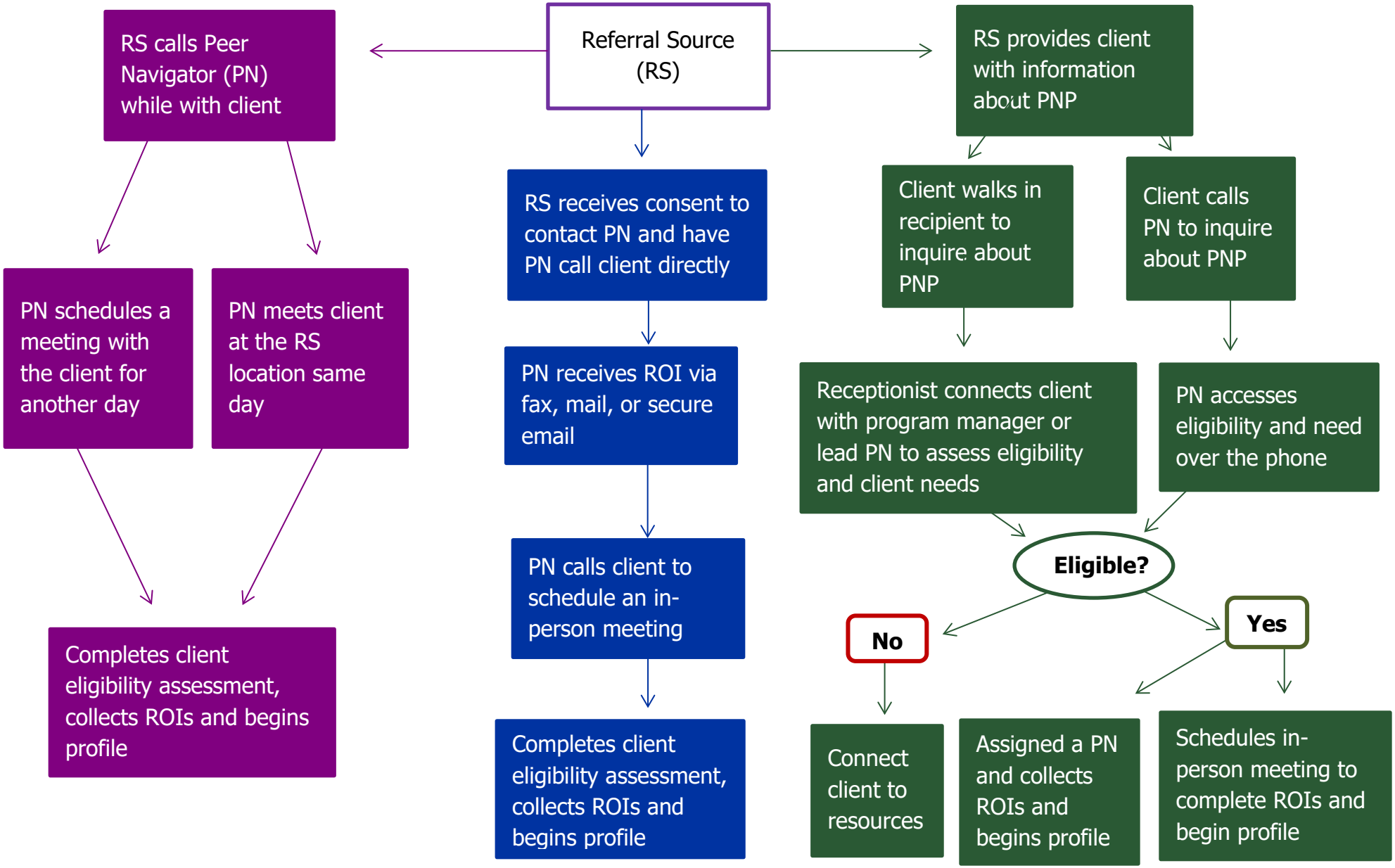
No contact

Peer navigators are required to follow up with their clients. If the peer navigator loses contact with a client they must follow the procedure outlined in the Universal Standards for "lost to follow up" clients. It is best practice to attempt contact via different means (for example, social media, home visit, texts) if peer navigator has signed consent to contact them for each type.

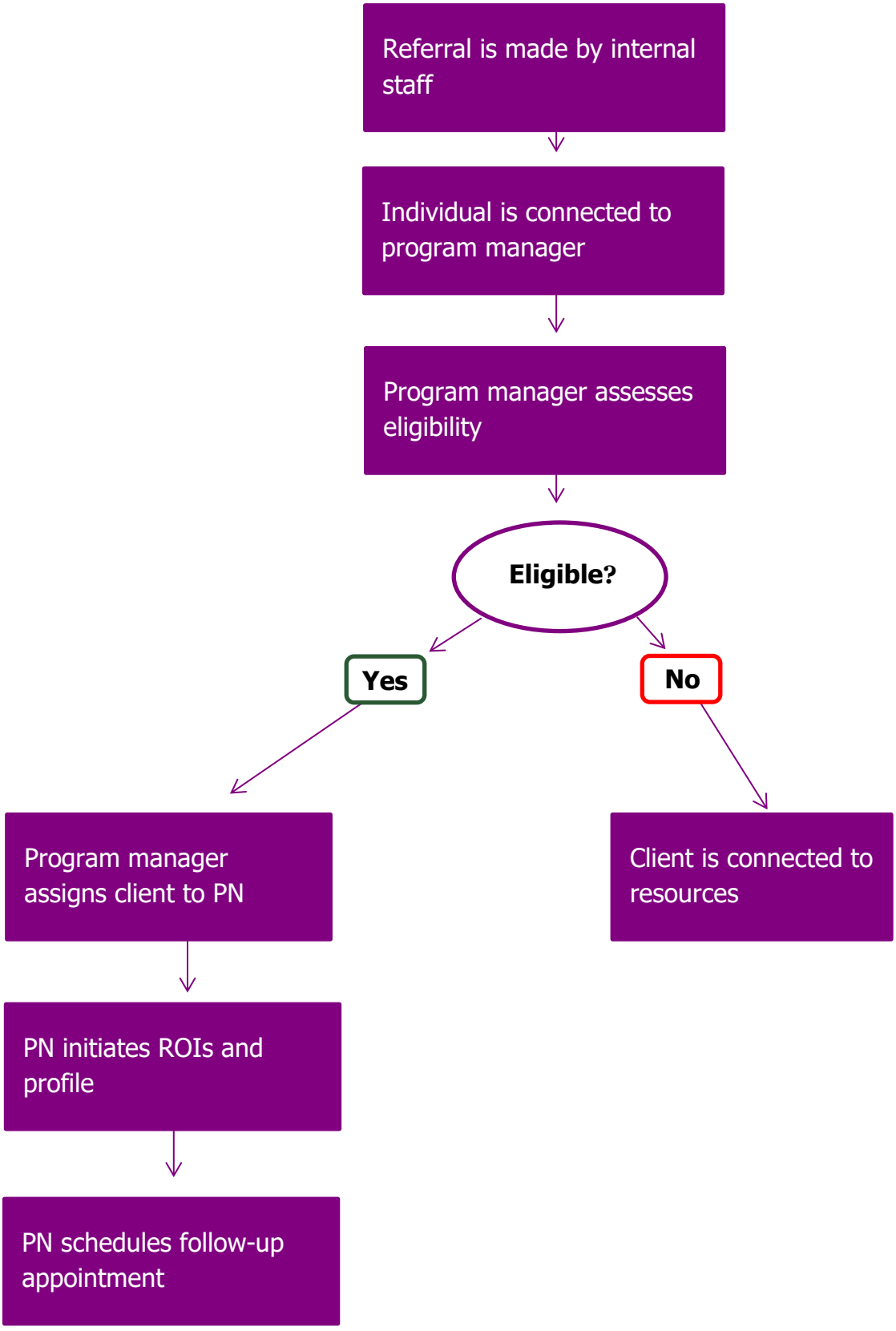
Reopening a case

A client's case may be reopened if either the client continues to face barriers to treatment adherence and is not self-sufficient or after a client contacts the peer navigator after the client's case has been closed due to no contact. However, the peer navigator is responsible for ensuring the client is reassessed and still eligible for the program. It is necessary for the client to complete all tasks as if they had never been a client before.

Appendix A: External Referral Workflow



Appendix B: Internal Referral Workflow



Appendix C: Wisconsin Ryan White Part B eligibility and recertification policy and procedures

This policy and related procedures cover client eligibility and recertification requirements that are associated with the delivery of HIV health and support services that are supported with federal Ryan White Part B funding awarded to the state of Wisconsin.

The federal Ryan White HIV/AIDS Program (RWHAP) provides a comprehensive system of care that includes primary medical care and essential support services for PLWH who are uninsured or underinsured. The federal Health Resources and Services Administration (HRSA) and the HIV/AIDS Bureau (HAB) within HRSA are responsible for administering the RWHAP. HRSA and HAB have policies that direct grantees and subgrantees in meeting the legislative intent of Ryan White funding.

HAB's National Monitoring Standards set the standards for meeting federal requirements for program and fiscal management, monitoring, and reporting. Section B of the national standards addresses eligibility determination, noting that service providers/subgrantees are required to conduct client annual and semiannual eligibility determination. The primary purposes of the eligibility certification are to ensure that residency, income, and insurance statuses of PLWH continue to meet the grantee eligibility requirements and to verify that the RWHAP is the payer of last resort. The recertification process includes checking for the availability of all other third-party payers.

It is important that clients understand that there are federal requirements for certification of initial eligibility and ongoing semiannual (six-month) recertification.

Initial eligibility determination requires providers to verify proof of:

- HIV infection, or for infants of indeterminate HIV status, proof that the person who gave birth is living with HIV.
- Income eligibility based on the family income limits for:
- HIV Care Grant services—500% of the federal poverty level (FPL).
- Wisconsin AIDS Drug Assistance Program—300% of FPL[1].
- Wisconsin AIDS/HIV Insurance Assistance Program—300% of FPL.[1]
- Wisconsin residence.
- Insurance coverage or proof of being underinsured or uninsured.

Semiannual (six-month) recertification requires providers to verify proof of:

- Low-income status.
- Wisconsin residence.
- Insurance coverage.

Table 1. summarizes the required eligibility documentation for initial eligibility determination and six-month recertification.

[1] For specific information regarding eligibility, recertification, and other requirements for the Wisconsin AIDS Drug Assistance Program and the Wisconsin HIV/AIDS Insurance Assistance Program, see the Wisconsin AIDS Drug Assistance Program Policy Manual at https://www.dhs.wisconsin.gov/publications/p01771.pdf.

Table 1. Required Eligibility Document

	At initial application and the comprehensive annual review	At six-month recertification
HIV status	Documentation is required.[2]	No documentation required.
Income	Documentation is required.	Record of self-attestation that indicates no change. If self-attestation notes a change, documentation of the change is required.
Residency	Documentation is required.	Record of self-attestation that indicates no change. If self-attestation notes a change, documentation of the change is required.
Insurance status	Documentation is required.	Record of self-attestation that indicates no change. If self-attestation notes a change, documentation of the change is required.

The use of self-attestation during recertification allows flexibility in meeting the needs of clients and in reducing the administrative burden of providers. Clients can self-attest by phone, email, or in person.

The following sections provide further detail regarding the eligibility criteria and procedures.

Verification of HIV status

The client must submit a physician's certification of their HIV-positive status. In the case of exposed infants with indeterminate HIV status, documentation must be provided certifying that the person who gave birth has been diagnosed with HIV.

Verification that client resides in Wisconsin

Clients must reside in Wisconsin in order to be eligible for RWAHP-funded services. Any one of the following documents is acceptable verification of Wisconsin residence:

- Most recent rental agreement or lease.
- Wisconsin driver's license or Wisconsin identification card.
- Most recent bill in the applicant's name.
- Statement from an authorized individual certifying current residence.

The documents listed above will only be accepted as proof of residency if they are:

- Current (within the last six months) and not expired.
- Show the name and the same address listed as client's physical address.
- Not a P.O. box address. Residency documents with a P.O. box are not acceptable.

[2] Documentation of HIV-positive status is only required one time—at initial eligibility determination.

Definition of family income

To be eligible for Ryan White services, family income cannot exceed the designated level of FPL (for example, 500% of FPL for HIV Care Grant services). Earned and/or unearned income received by the client or the client's legal spouse is counted toward overall family income.

For clients between ages 18 and 26 years **insured by parents** and **employed**, both the client and parents' income are counted toward the family income, and both the client and parents are counted toward the family size.

For clients between ages 18 and 26 years **insured by parents** and **unemployed**, the parents' income is counted toward the family income, and parents and client are counted toward the family size.

Earned and/or unearned income received by any of the following individuals **does not** count toward overall family income:

- Client's registered domestic partner.
- Client's spouse if legally separated.
- Client's dependent children under 18 years of age.
- Client's parents if client is over 18 years of age, employed, provides own health insurance, and lives with parents.

Definition of family size

Family size is a factor in determining family income as it relates to the federal poverty guidelines. Individuals counted toward family size include:

- Client.
- Client's legal spouse (except if legally separated).
- Client's registered domestic partner.
- Client's children under 18 years of age that the client claims as dependents on their income taxes.

Verification of income

Table 2 identifies countable sources of family income and acceptable income verification documents.

Table 2: Sources of Income and Acceptable Verification Documents

Countable Sources of Income	Acceptable Verification Documents
Gross wages and salary	Most recent paycheck stub (within the last 60 days) from all employers. Most recent Internal Revenue Service (IRS) form 1040 if you are self-employed
Social Security Disability Insurance (SSDI)	Most recent award letter from SSA
Social Security Supplement Income (SSI)	Most recent award letter from SSA
Dividends and interest	Most recent form 1040 Schedule B or most recent form 1099
Estate/trust income, net rental income, and/or royalties	Most recent IRS form 1040 Schedule E
Public assistance	Most recent award letter
Pensions, annuities, and/or veteran's pensions	Most recent letter stating pension/annuity amount
Unemployment and/or worker's compensation	Most recent letter stating amount of unemployment/ worker's compensation benefit

Note: Tax forms from prior years will not be accepted as verification of income.
Finances not counted as income include:

- Proceeds from the sale of an asset
- Gifts
- Inheritance
- Life insurance proceeds
- One-time settlements
- Income tax refunds

Documentation for a client who does not have any income must state how they are being supported financially. A written statement from the person or organization that supports a client financially may be accepted.

If the client is unable to obtain proof of income, a written statement from a case manager or employer (on company letterhead) that indicates an average income may be accepted.

A client determined to be ineligible for the program or whose participation has been terminated may reapply at any time.

Calculation of income

Sources of income from all family members are counted toward overall family income.

For clients who earn wages through employment, income is calculated by using the following recommended methods. The lesser of the two calculations is used in determining the applicant's eligibility.

Method 1

The year-to-date (YTD) gross income from the applicant's pay stub is divided by the number of paychecks the applicant has received during the calendar year. To obtain the applicant's annual income, the resulting amount is multiplied by either 52 (if paid weekly) or 26 (if paid biweekly).

Sample calculation

A person employed full time applies for Ryan White services on April 15 and submits a pay stub for a biweekly pay period that ended on Friday, March 28. This means that the person would have received six paychecks during that time. The gross YTD income listed on the pay stub is $6,924. This amount divided by the six paychecks is equal to $1,154 per pay period. Since the applicant is paid biweekly, this number is multiplied by 26 to obtain an annual income of $30,004.

Method 2

This method utilizes the applicant's hourly rate to determine annual income. The hourly rate listed on the pay stub is multiplied by 2080 hours for full-time employees.

Sample calculation

The pay rate listed on the pay stub for the applicant in the previous example is $14.45/hour. Since the applicant is employed full time, this amount is multiplied by 2080 (hours) to obtain an annual income of $30,056. If the applicant works less than full time, the hourly rate is multiplied by the number of hours the applicant works within the year.

The lesser amount (in this case, $30,004) from the two methods is used as the annual income for purposes of eligibility determination.

For clients who receive monthly income from sources such as pensions, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), or public assistance income is determined by multiplying the monthly amount by 12.

Once calculated, family income and family size are used to determine the client's income as it relates to the federal poverty guidelines, which are updated annually around March 1. Only clients with calculated incomes at or below the designated threshold of FPL are eligible for services. The federal poverty guidelines are updated annually and are located on the U.S. Department of Health and Human Services webpage at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

Verification of insurance status

Insurance coverage status is both an eligibility issue and a payer-of-last-resort compliance issue. Clients must be recertified at a minimum of every six months to establish eligibility for Ryan White

HIV/AIDS Program services, which includes checking for insurance or other third- party payers, such as Medicaid, Medicare, and Medicare Part D. Clients with insurance who are underinsured may continue to be eligible for Ryan White HIV/AIDS Program services. For further clarification, please reference the HRSA Policy Clarification Notice (PCN) #13-02.

Providers must assess and document the client's insurance status and document if the client is eligible from other third-party payers.

Eligibility and recertification data sharing

RWHAP-funded providers may utilize certification data-sharing agreements with other RWHAP grantees and/or subgrantees in order to reduce burden on grantees, subgrantees, and clients. A single client eligibility record is acceptable only if all of the following criteria are satisfied:

- RWHAP-funded providers must have the same eligibility criterion that meets the requirements (that is, use the same percentage of FPL to establish eligibility).
- There must be an application with supporting documentation (for example, income and insurance verification).
- The application and supporting documentation must be available for review at each of the providers' sites.
- The individual provider must be aware that the responsibility of providing allowable services to eligible clients still rests with the individual provider.

The sharing of eligibility application and documentation can be done by copying the original application and documents or by electronic access to the application and documentation.

Appendix D: Medical transportation log instructions and sample

Instructions: Complete one line for each instance of transportation assistance. For example, if you are providing eight bus tickets to allow a client to attend four medical appointments (round trips), you should enter data on four separate lines (one per appointment).

Client identifier and name of staff person arranging for transportation	Type of service for which transportation is provided	Trip description and date	Trip origin	Trip destination	Transportation method provided	Dollar value of the assistance provided	Method of follow up verification
_____ Client ID _____ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing assistance ☐ Other* _____	☐ One-way ☐ Round-trip ☐ Other _____ _____ Trip date: ___/___/____	☐ Client home ☐ Other _____ _____ _____ _____	☐ Provider (name) _____ _____ _____ ☐ Other _____ _____ _____ _____	☐ Bus ticket(s) (how many? _____) ☐ Taxi fare(s) (how many? _____) ☐ Gas gift card(s) (how much? _____) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* _____	_____ (number) of tickets/fares/trips/miles at $_____ per ticket/fare/trip/mile equals $ _____ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other _____ _____
_____ Client ID _____ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing assistance ☐ Other* _____	☐ One-way ☐ Round-trip ☐ Other _____ _____ Trip date: ___/___/____	☐ Client home ☐ Other _____ _____ _____ _____	☐ Provider (name) _____ _____ _____ ☐ Other _____ _____ _____ _____	☐ Bus ticket(s) (how many? _____) ☐ Taxi fare(s) (how many? _____) ☐ Gas gift card(s) (how much? _____) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* _____	_____ (number) of tickets/fares/trips/miles at $_____ per ticket/fare/trip/mile equals $ _____ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other _____ _____
_____ Client ID _____ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing Assistance ☐ Other* _____	☐ One-way ☐ Round-trip ☐ Other _____ _____ Trip date: ___/___/____	☐ Client home ☐ Other _____ _____ _____ _____	☐ Provider (name) _____ _____ _____ ☐ Other _____ _____ _____ _____	☐ Bus ticket(s) (how many? _____) ☐ Taxi fare(s) (how many? _____) ☐ Gas gift card(s) (how much? _____) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* _____	_____ (number) of tickets/fares/trips/miles at $_____ per ticket/fare/trip/mile equals $ _____ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other _____ _____

________________ Client ID ________________ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing assistance ☐ Other* ____________	☐ One-way ☐ Round-trip ☐ Other ________ ________ Trip date: ___/___/____	☐ Client home ☐ Other ______ ___________ ___________ ___________	☐ Provider (name) ___________ ___________ ___________ ☐ Other ________ ___________ ___________ ___________	☐ Bus ticket(s) (how many? ______) ☐ Taxi fare(s) (how many? ______) ☐ Gas gift card(s) (how much? ______) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* ___________	________ (number) of tickets/fares/trips/miles at $______ per ticket/fare/trip/mile equals $ ________ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other ____________ ____________
________________ Client ID ________________ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing assistance ☐ Other* ____________	☐ One-way ☐ Round-trip ☐ Other ________ ________ Trip date: ___/___/____	☐ Client home ☐ Other ______ ___________ ___________ ___________	☐ Provider (name) ___________ ___________ ___________ ☐ Other ________ ___________ ___________ ___________	☐ Bus ticket(s) (how many? ______) ☐ Taxi fare(s) (how many? ______) ☐ Gas gift card(s) (how much? ______) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* ___________	________ (number) of tickets/fares/trips/miles at $______ per ticket/fare/trip/mile equals $ ________ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other __________ __________
________________ Client ID ________________ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing assistance ☐ Other* ____________	☐ One-way ☐ Round-trip ☐ Other ________ ________ Trip date: ___/___/____	☐ Client home ☐ Other ______ ___________ ___________ ___________	☐ Provider (name) ___________ ___________ ___________ ☐ Other ________ ___________ ___________ ___________	☐ Bus ticket(s) (how many? ______) ☐ Taxi fare(s) (how many? ______) ☐ Gas gift card(s) (how much? ______) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* ___________	________ (number) of tickets/fares/trips/miles at $______ per ticket/fare/trip/mile equals $ ________ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other __________ __________
________________ Client ID ________________ Staff name (print)	☐ Medical (outpatient) ☐ Mental health ☐ Substance use ☐ Food bank ☐ Dental/oral health ☐ Legal support ☐ Medical case management ☐ Other case management ☐ Housing Assistance ☐ Other* ____________	☐ One-way ☐ Round-trip ☐ Other ________ ________ Trip date: ___/___/____	☐ Client home ☐ Other ______ ___________ ___________ ___________	☐ Provider (name) ___________ ___________ ___________ ☐ Other ________ ___________ ___________ ___________	☐ Bus ticket(s) (how many? ______) ☐ Taxi fare(s) (how many? ______) ☐ Gas gift card(s) (how much? ______) ☐ Mileage reimbursement ☐ Other transportation contractor ☐ Use of agency vehicle ☐ Ride from volunteer or staff driver ☐ Other* ___________	________ (number) of tickets/fares/trips/miles at $______ per ticket/fare/trip/mile equals $ ________ total cost	☐ Accompanied client on trip ☐ Provider verification ☐ Client self-report on ___/___/____ ☐ Other ____________ ____________

*Types of services eligible for transportation assistance, and methods of transportation, are strictly limited by federal and state guidelines. Before checking "other," verify that the proposed assistance is allowable.