THE PEER NAVIGATOR PROGRAM FOR PEOPLE LIVING WITH HIV MANUAL

Wisconsin HIV Program

Wisconsin Policies, Procedures & Protocols

WISCONSIN DEPARTMENT of HEALTH SERVICES

P-02811 (10/2020)

HIV Program Contact List

General HIV Program Number: 608-267-5287

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Common Acronyms

Ag/Ab – Antigen/antibody

AIDS – Acquired immunodeficiency syndrome

ASO – AIDS Service Organization

CBO – Community-based organization

DHS – Department of Health Services

DPH – Division of Public Health

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

Definitions 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.

AIDS: Stands for acquired immunodeficiency syndrome. 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 count drops below 200 cells per micrometer or if they develop a certain opportunistic infection.

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.

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

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.

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

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.

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 taking HIV medicines every day and exactly as prescribed (called medication adherence).

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.

Viral load suppression: When there is 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.

Introduction and Background

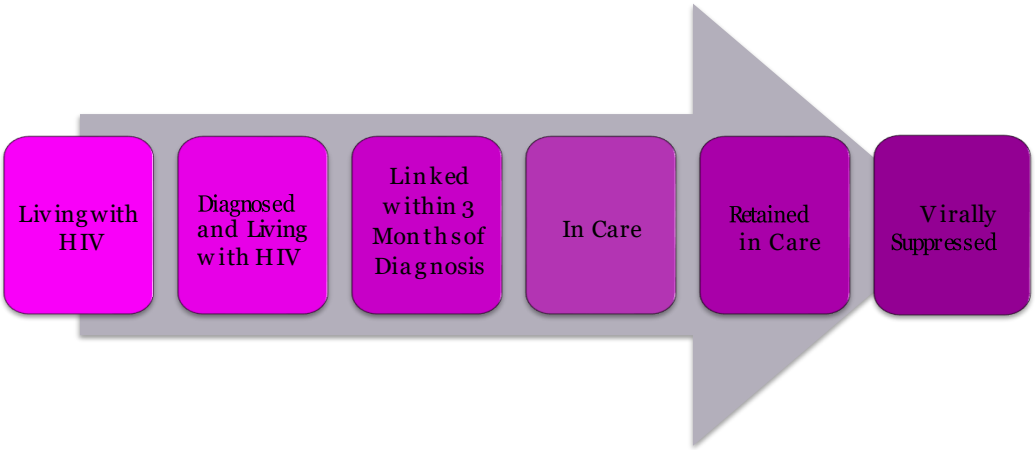
Summary

There is a growing understanding that the traditional health care system does not meet the needs of persons with HIV. Wisconsin has a well-established system of care to link and relink people living with HIV to appropriate care services. The model of clinical care includes the provider, the nurse, a Linkage to Care Specialist, and/or a Medical Case Manager who work collaboratively to link and retain patients in care, prescribe antiretrovirals (ARVs), and achieve viral load suppression (VLS). The background and expertise of each type of service provider is important in addressing the medical needs of people living with HIV as well as barriers that prevent people living with HIV from engaging in care. When this established system of care fails to meet the needs of clients, as shown by non-suppressed virus and lack of clinic visit attendance, it is essential that providers and people living with HIV have access to new approaches to care. The integration of trained peers, known as Peer Navigators is one example of this approach.

HIV Care Continuum

The HIV care continuum is a model that outlines the sequential stages of HIV medical care a person living with HIV goes through. Often, the model illustrates the proportion of individuals living with HIV who are engaged at each stage as a means of identifying gaps in HIV medical care. In order to benefit from adequate treatment and attain viral suppression, an individual living with HIV must first know they are living with the virus. Connection to and engagement in care is necessary to receive and adhere to effective antiretroviral medication. There are substantial obstacles that contribute to poor engagement in HIV care, resulting in poor health outcomes for the individual living with HIV and a potential risk of HIV transmission.

Ensuring people living with HIV have the resources and support to actively engage in care and meet each stage of the continuum will improve their quality of life.



Intended Audience for this Manual

This manual is intended for agencies funded by the Wisconsin Department of Health Services, Division of Public Health (DPH) HIV Program, to provide peer navigation services to people living with HIV who are not engaged in care. It is expected **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
- Outline expectations and minimum requirements of the Peer Navigator Program

Agencies funded for 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 and memoranda of understanding (MOUs) with the DPH. This Manual is not all encompassing but provides the **minimum** requirements for the program. It is expected that agencies implementing the Peer Navigator Program will exceed minimum requirements as appropriate to agency's capacity and the needs of their communities. Throughout this Manual, the terms *navigator* and *provider* are used interchangeably and refer to the same role.

Purpose of the Peer Navigator Program

The DPH HIV Program and its partners developed a public health intervention, known as the Peer Navigator Program for People Living with HIV, to reengage PLWH 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.

Agencies 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)
- 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
- Appropriate referrals for medical and social services resources and community resource navigation
- Complimentary support to existing care team and interdisciplinary team collaboration

Target Audience for Peer Navigator Services

The Wisconsin Peer Navigator Program is designed to serve those individuals who have been diagnosed with HIV at least 13 months ago and are not linked to, engaged in, or adhering to treatment and HIV care services and are not virally suppressed. Peer Navigator services are currently restricted to residents of Milwaukee County. Residents outside of Milwaukee County should be referred to appropriate services in their desired location. The Peer Navigator Program is designed with the goal to serve key populations living with HIV and who are lost to care.

Key populations are defined as:

- Gay, bisexual, queer, SGL and other men who have sex with men (MSM)
- Men who have sex with men and inject drugs (MSM/PWID)
- Transgender women who have sex with men
- People who inject drugs
- Cis-gender women, ages 25 and older
- Young men who have sex with men, particularly Black/African American and Hispanic/Latino men ages 13-24

Client Eligibility

Participants eligible for Peer Navigator services must meet all of the following criteria:

1. Reside in Milwaukee County
2. Have been diagnosed with HIV at least 13 months ago
3. Not engaged in care
4. Low-income

And meet one of the following criteria:

5. Documented at-risk for falling out of care (for example, homelessness, loss of health insurance)
6. Not linked to care
7. A repeated history of falling out of care
8. A repeated history of not adhering to HIV treatment
9. Not virally suppressed

Ryan White Part B Eligibility

To meet federal requirements, clients must also meet the following:

- HIV infection
- Income eligibility based on the family income limit of 500% of the federal poverty level
- Wisconsin resident
- Insurance coverage or proof of being underinsured or uninsured

More details, including definitions and acceptable verification documents are explained in Appendix A.

Program Goals

Increasing the number of individuals living with HIV who are virally suppressed is the ultimate goal of the Peer Navigator Program. Addressing the social determinants of health will be the only feasible way of ensuring the goal is achieved. However, the success of the program is not only measured by the outcome of viral load suppression. Instead, the Peer Navigator should realize that overcoming any barrier their clients feel is hindering their abilities to manage their HIV, is a progressive step forward. The Peer Navigator should continue working with their client along this journey to viral suppression.

Program goals include:

1. Increasing the number of participates achieving viral load suppression
2. Decreasing barriers to achieving viral load suppression
3. Decreasing the number of participants who are lost to care
4. Reducing HIV-related disparities and health inequities
5. Increasing community awareness of the Peer Navigator Program

Participants in the Peer Navigator Program should, at minimum, obtain the following skills and knowledge:

- Self-advocacy in medical and social services settings
- Understanding their lab reports
- Communicating effectively and efficiently with their providers
- Navigating, requesting, and receiving community resources
- Basic HIV information, including the importance of treatment adherence and viral suppression
- Strategies to remember taking their HIV treatment and attending appointments
- Removing barriers to managing their health

Program Requirements

Agency Requirements

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

Laws and Wisconsin HIV Program Protocols

- Adhere to state statutes (laws) related to HIV, including those concerning confidentiality, informed consent for testing, and HIV case reporting (§ 252). (https://www.dhs.wisconsin.gov/publications/p4/p44295.pdf)

- Comply with state statute and Wisconsin HIV Program's data collection, entry, and reporting requirements – including mandated quarterly and annual reports.

- Provide services to clients meeting eligibility without discrimination based on protected status.

- Participate in, in entirety, mandatory pre-training educational modules, core training curriculum, and continuing educational opportunities when requested by the Wisconsin HIV Program.

- Adhere to and provide deliverables outlined in contractual agreements with the Wisconsin HIV Program and inform the State HIV Program of any expected delays.

- Obtain memoranda of understanding (MOUs) with other local agencies to provide Peer Navigators shadowing and practicum experience.

- Comply with all policies, procedures, and protocols outlined in this Manual.

Referrals

- Coordinate with other local agencies to facilitate referrals related to HIV and STD 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 Peer Navigator Program 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 to provide external Peer Navigator referrals.

Internal Agency Procedures

- Monitor quality of services through observation of provider-client sessions, client satisfaction surveys, or other means, within agency limits.
- Establish agency specific policies and procedures for referrals, service delivery, transportation, conduct, and confidentiality in a manner consistent with all core requirements, program protocols, and Wisconsin statutes.
- Agencies are expected to provide culturally competent services, to recruit and retain staff members who are reflective of the population served, and to involve a diverse group of individuals in the planning, design, and implementation of services.
- Have physician, nurse practitioner, or physician assistant licensed in the State of Wisconsin and have experience in HIV medical care provide medical oversight of Peer Navigator Program activities, including review and written approval of Peer Navigator Program agency policies and procedures.
- Provide the Wisconsin HIV Program with detailed policies and protocols for maintaining professionalism and boundaries between Peer Navigator Program staff and clients/community members, maintaining confidentiality, and actions and disciplinary plan in the event of intentional or unintentional breach(s) of confidentiality.

Staff Training Requirements

Wisconsin HIV Program Trainings

Peer Navigators, including Program Manager are required to attend the following Wisconsin HIV Program sponsored trainings in sequential order:

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.
- **HIV Basic Facts online training must be completed before the participant attends the in-person Core Training.**
- 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.
- **Hepatitis C Basic Facts online training must be completed before the participant attends the in-person Core Training.**
- Submission of Certificate of Completion is required.

Core Training (in-person)

- The Core Training is a five (5) consecutive day training, facilitated in-person. Each day will introduce new material, while building upon previous lessons.
- The Core Training will consist of group activities, practice sessions, and individual learning activities.
- Participants are required to attend all five days, in their entirety. Missed days will result in termination of employment.

Motivational Interviewing (MI) Competency Certificate (in-person)

- The MI Training is a 40-hour certification program that provides opportunity to develop skills in motivational interviewing through interactive seminars, workbook readings, written assignments, and fidelity reviews of practice samples

with performance-based feedback.

- The Training is scheduled two (2) consecutive eight-hour days, once a month for 3 months.
- **Participants are required to attend all 6 days, in their entirety.**
- Successful completion of the course and earning of the Certificate of Competency is required.

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 should be protected and upheld. Program staff needs to be aware of the various ways that client confidentiality can be compromised, including in-person, on the phone, through email, texting, or through social media and the handling of hard copy documents. As part of their role, Peer Navigators and the Program Manager may work off-site and interact with providers on their client's behalf, which can increase the risk for breach of confidentiality of client protected information. Specific measures to ensure confidentiality is upheld when off-site must be taken.

- Confidential client information should be kept in locked file cabinets in a locked room.
- When working off-site, client information should be transported in portable, locked file containers. Ensure this information is securely stored in the vehicle's locked trunk and not visible in the vehicle. All files should be returned to the agency at the end of the provider-client session. This should be done in a manner that addresses both staff safety and record security when conducting off-site sessions, especially late night and after business hours.
- Files should not be left in motor vehicles or staff homes overnight.

- Never share your ID or passwords with anyone and do not allow using the computer while you are logged in. Individual users should have individual login IDs and secure, individual passwords.

- Make sure you log off any electronic devices when you're not using them or you step away from them, no matter how long you'll be away.

- Use secure shredder bins to dispose of documents containing confidential information.

- Maintain possession of mobile devices (i.e. laptops, smartphones, USB flash drives, tablets, etc.) 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.

- Provider-client sessions at agencies should be provided in a private, comfortable, nonthreatening environment that will foster open discussion and ensure confidentiality.

- Provider-client sessions that are off-site must be done in a private environment that will foster open discussion and ensure confidentiality (i.e. reserved study room at local library or university, client's home when no-one is around, etc.).

- Access to client information and records must be limited to those with a legitimate need to access the documents (for example supervisory oversight staff, medical providers, and so on).

- Agencies must 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.

- Agencies should review confidentiality policies and monitor agency 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. The Navigator should never reveal the client's participation in the program to anyone without express consent from the client and proper documentation of informed consent. **The Peer**

Navigator should never acknowledge their client first. If the client acknowledges the Peer Navigator first then it is permissible to interact.

Clients and Navigators may have preexisting relationships or may have mutual acquaintances. Every effort should 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 agency providing Peer Navigation services must have a policy in place to address such concerns and made available to each Peer Navigator.**

HIV Disclosure

Additional laws protect people living with HIV and their HIV-related information. Unintentionally or intentionally disclosing another person's HIV status without consent can result in monetary fines and time in prison.

Peer Navigators should feel comfortable disclosing their HIV status and/or their experiences with HIV to their clients. The Peer Navigator Program is unique and distinguishes itself from traditional care services because of the shared experience of living with HIV between the provider and client. This key aspect to the program has been established in research as having positive health outcomes for individuals living with HIV.

It is important that the Peer Navigator discuss with their clients any limitations they have in regards to disclosing their status on their behalf.

Wisconsin penalties related to HIV disclosure are described below:

Civil Penalties

Unintentionally disclosing someone's HIV status will result in actual damages plus exemplary damages up to $2,000 plus attorney fees within the State of Wisconsin. Intentional disclosure of someone's HIV status will result in actual damages plus exemplary damages up to $50,000 plus attorney fees within the State of Wisconsin.

Criminal Penalties

Individuals convicted of disclosing someone's HIV status negligently in a way that results in harm to the individual may be fined up to $50,000 and up to nine months in jail in the State of Wisconsin. Individuals convicted of intentionally disclosing someone's HIV status for monetary gain will be fined up to $200,000 and up to 3.5 years in state prison. Negligently disclosing someone's HIV status can result in a fine up to $2,000 within the State of Wisconsin.

Informed Consent

Informed consent is the process by which the provider discloses appropriate information to a competent client so that the client can make a voluntary decision to accept or refuse care. All reporting requirements should be explained to the client.

Informed consent must be documented and signed by both the provider and the client and maintained in the client's files. The client has the right to terminate services by written request; this written request should be maintained in the client's files.

Electronic Communication

Electronic communication refers to text, e-mail, iMessage, social media, and any other form of communication done using the internet or WiFi.

Risk of Using Electronic Communication

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

- E-mails and social media addresses/handles may be easily misread and therefore addressed to unintended recipients.
- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted.
- 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 electronic 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 on-line services have a right to inspect e-mail transmitted through their systems.

- Electronic communications may be hacked or attacked by viruses, making the data exchanged vulnerable.

- E-mail 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 the only individual capable of receiving the electronic communications. Peer Navigators must explain the risks of using electronic communications to their clients and confirm their client's consent to such communications by signing the Consent to Follow-Up form. Electronic communications are subject to, but are not limited to, the following conditions:

- All electronic communications must be documented using the Care Coordination Systems, detailing the mode of communication (for example, text, social media, e-mail), date, extent of the communication, and result of the communication.

- All electronic communications must never be altered, deleted, or edited to falsify information.

- All electronic communications may be printed and stored in the client's records or uploaded and stored in the Care Coordination Systems.

- An in-person meeting or phone call should be scheduled when discussing sensitive information that is not suitable for electronic communications.

- Electronic communications should not be used to discuss 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.

- Refrain from using emojis or other characters when communicating with clients in order to limit misunderstandings. Document emojis and other characters in Care Coordination Systems, when used. An explanation of the emoji or character meaning may need to be stated when documenting in Care Coordination Systems, when unclear.

- All breaches or suspected breaches of confidentiality must be reported to the Wisconsin HIV Program within the time described in Wisconsin statues.

Reporting Requirements

Providers are required by Wisconsin statutes to report certain information to authorities regardless of client consent. **Learned or observed abuse or neglect should be reported directly to the provider's supervisor and follow federal, state, and local laws and agency policies and protocols.** Only necessary and relevant information pertaining to the abuse or neglect is permitted to be shared to appropriate authorities – do not disclose unnecessary confidential information. Each agency must have protocols in place to address the following.

Providers learning of or observing the following must report to it to their supervisor:

Child abuse

If there is a reason to believe that a child under the age of 18 is being physically or sexually abused, providers are required to report this information to their superior or appropriate state agency.

Elder/Adult-at-risk abuse

Any person age 60 or older and/or any adult with a physical or mental condition that impairs the ability to care for their needs and has experienced, is experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation should be reported to the appropriate authorities.

Danger to oneself or others

If a client expresses harming themselves or someone else and there is belief that the threat to be serious, it is obligated under the law to take necessary actions to protect the individual(s) from harm. Only directly relevant information is allowed to be shared in this case only to individuals who need to know to intervene in the crisis.

Record Keeping Requirements

A paper file should be established for each client receiving Peer Navigator services. These forms and documents are addition to, and support information collected in Care Coordination Systems. The file should retain copies of all Wisconsin Peer Navigator Program documents and data collection forms used as part of Peer Navigator services. The forms at minimum will include: Consent to Follow-Up Form (see Appendix A), Authorization for Release of Confidential Information (see Appendix B), Grievance Acknowledgment Form, Client Agreement Form (see Appendix C), and copies of clinical records.

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 and the provider is obligated to adhere.

Material Review Requirements

Agencies receiving funding from the DPH for Peer Navigator services must document review and approval of HIV-related materials used for the Peer Navigator Program by the authorized clinician performing clinical oversight of the Peer Navigator Program.

Examples of HIV-related materials that must be reviewed and approved include HIV-related written materials, visuals, audiovisuals, questionnaires, survey instruments, the content of educational sessions, and HIV-related web-based materials posted on the internet. This requirement has been established by federal regulation and is enforced by the Centers for Disease Control and Prevention (CDC).

This requirement does not apply to materials the agency uses that were produced or purchased by the CDC or the Wisconsin HIV Program.

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 agencies providing Peer Navigator services and should be made available to all Peer Navigator Program 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:

1. Accuracy
2. Completeness
3. Consistency
4. Uniqueness
5. Timeliness

Minimum DHS Quality Assurance Requirements Checklist

- ☐ Review program materials for cultural appropriateness.
- ☐ Evaluate the physical space and client confidentiality system of in-agency services.
- ☐ Review and/or update referral lists **annually**.
- ☐ Review record keeping and security practices **quarterly**.
- ☐ Monitor accuracy of data collection and entry **monthly**.
- ☐ Review client outcomes **quarterly**.
- ☐ Present client cases **monthly**.
- ☐ Conduct client satisfaction surveys.

Quarterly In-Person Check-Ins

The Wisconsin HIV Program will conduct quarterly in-person check-ins the first year of program implementation to ensure quality assurance policies and procedures are upheld. The Program Coordinator will also meet with each program staff individually to discuss any concerns and to simply check-in and establish support.

Site Visits

Agency sight visits will be held annually in the fall quarter between October and November. The agency will receive advanced notice of the site visit date(s) and necessary instructions to prepare for the site visit. Site visits are a chance for the Wisconsin HIV Program and the program staff to meet and discuss the function of the program and hear from the program staff personally. Site visits are also intended to ensure program policies, procedures, and protocols have been met and to review files.

Documentation Requirements

Summary

To evaluate the Peer Navigator Program utilization and effectiveness, accurate and timely documentation of client data and services provided are necessary. Documentation requirements and their deliverables vary depending on the program staff's role and responsibility.

Data Entry and Confidentiality

Ensuring confidentiality and security of client records is imperative for the integrity of Peer Navigator Program. It is not permissible for program staff to enter data from a home computer or from an agency laptop in their home. All Release of Information forms and any other consent forms must be documented and stored in the client's file.

Quarterly Reports

Funded agencies are required to submit quarterly narrative reports pertaining to program activities and progress. **Quarterly reports should be submitted via email to the Program Coordinator.**

The narrative should briefly and specifically address the following points:

- Answer all questions posed in the quarterly template

- Any changes or requested changes to the approved Work Plan, including changes to service delivery, program activities, staff changes, receipt of additional private or public funds to support peer navigation services
- Program successes and achievements
- Barriers and challenges to reaching key populations and/or anticipate outcomes
- Technical assistance needs
- Other comments the agency feels necessary to include

Narrative reports should be submitted in **via email by 5pm** on the due date.

Due dates are as follows:

Quarter	Parameter	Report Due
Q1	Jan. 1–Mar. 31	**April 30**
Q2	April 1–June 30	**July 31**
Q3	July 1–Sept.30	**Oct. 31**
Q4	Oct. 1–Dec. 31	**Jan. 31**

Agency Perspective Report

The Program Manager will be required to submit the report to the Program Coordinator detailing the agency's perspectives on how the program functioned. This is an opportunity for the agency and program staff to reflect on the year of implementation as a whole and detail the program's strengths, limitations, and recommendations for change to the Wisconsin HIV Program. This report should be specific to the agency's own workflow, experiences, and adaption to the program's policies, procedures, and protocols. Details on format and prompts will be provided to the agency during the 4th quarter of implementation.

Medical Transportation Assistance

Medical transportation assistance is the provision of non-emergency transportation services that enables people living with HIV (PLWH, referred to here as "client") to access or be retained in HIV-related core medical and/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 and Life Care Services 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 subrecipient offers cab or ride services and other modes of transportation, the subrecipient should have an established policy that explains how the subrecipient determines which form of transportation assistance is used in different circumstances.

All medical transportations issued must be documented using the Medical Transportation Log (see Appendix D). Instructions to complete the Medical Transportation Log are detailed in Appendix E.

Transportation for Ryan White-Funded Staff

Transportation for Ryan White-funded staff is the provision of transportation services that allow the staff person to complete their job duties. Any funds used to provide transportation to Ryan White-funded staff, such as peer navigators and case managers, is considered part of the Ryan White service category for which that staff person is funded. For example, the mileage for a medical case manager to travel from their office location to meet a client at a public location is considered part of the medical case.

Transportation for Peer Navigators must be documented using the Medical Transportation Log (see Appendix H).

Mileage Reimbursement

Only travel deemed necessary to perform core work responsibilities will be eligible for mileage reimbursement. All travel should be correlated with accurate documentation in the Care Coordination Systems (CCS) and Medical Transportation Log 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 agency 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.

Case Notes

Client case notes are the responsibility of the Peer Navigator or any other personnel interacting with a client through the Peer Navigator Program. All case notes must be electronically entered into CCS **within 72 hours of the day of interaction**. All case notes that detail a crisis needing urgent response (e.g. threats of suicide, incidents of rape, abuse, etc.) must be entered **within 24 hours of the incident.**

Case notes should be specific, detailed, concise, and understandable. Case notes 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 case notes.

Individual Supervision

A brief summary of individual supervision of each Peer must be documented by the Program Manager for each session. If applicable, the summary must include any disciplinary action taken, concerns addressed, individual performance review summary, and plan to improve or maintain performance. Information obtain from individual supervisions may be used to support the quarterly reports.

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 via any interaction** (for example phone, in-person, social media, etc.). Any attempt to contact the client without success is considered a touch. Appropriate documentation of the interaction and every attempt to contact the client is necessary. Even if a client does not answer the phone or is unable to be reached, detailing attempts and outcomes need to be documented.

At minimum, the Peer Navigator must meet with the client in-person every two months. Location of the in-person check-in may be determined by the client, if reasonable and agreed upon by the Peer Navigator.

After every referral, the Peer Navigator should **follow-up with the client within 72 hours of the referral appointment date**. A referral is any resource provided to the client to address any needs they have. The follow-up should inquire if the referral appointment was attended or not, issues or concerns that arose, reason appointment was not followed through, if applicable, and if the referral benefited the client. Proper documentation within CCS of follow-up is necessary. Appointments attended by the Peer Navigator and client must also be documented in CCS within 72 hours.

Client Agreement Form

The Client Agreement Form is a document that briefly highlights expectations of the client while participating in the Peer Navigator Program. The form should be explained to the client by the Peer Navigator during the initial meeting. The Peer Navigator should ensure the client understands the agreement and is allowed any time to ask questions or express concerns they may have. Both the client and the Peer Navigator must sign the form. A copy should be given to the client. The original with both signatures must be stored in the client's file.

This agreement is to be used to foster a respectful relationship between the client and the Peer Navigator, as well as between other clients and staff. If the client does not follow the agreement, the Peer Navigator may reference the agreement with the client and work with the client to establish a respectful working relationship. Extreme violations of the agreement should be handled via agency protocols, policies, and procedures and/or State statues, if applicable. It should be understood that some violations of the agreement may happen and the Peer Navigator should respond and address the violations reasonably and in accordance with the Program Manager.

Consent to Follow-Up Form

The Consent to Follow-Up Form is used to gain permission to follow-up with the client and to identify how and when the client may be contacted. It is important that the Peer Navigator explains this form thoroughly and ensure the client understands how and when the client may be contacted by the Peer Navigator. Any changes to the Consent to Follow-Up Form should be documented and a new Consent to Follow-Up Form must be signed and agreed upon. Both the client and the Peer Navigator must sign the form. A copy should be given to the client. The original with both signatures must be stored in the client's file.

Program Staff Roles and Responsibilities

Peer Navigators

Peer Navigators are unique members of the care team because they are individuals living with HIV or highly impacted by HIV through the diagnosis of their loved one(s). As a result of this shared experience, Peer Navigators can provide additional support by sharing strategies to overcome barriers to achieving viral suppression. It is these experiences that can benefit clients living with HIV that they do not receive from traditional approaches to care from professionals not living with HIV.

It is expected that the Peer Navigator **follows the HIV HUB Protocol** (see Appendix F) when working with clients.

Roles and Responsibilities

Refer, link, and engage clients to clinical, psychological, and other support services

Peer Navigators should have extensive knowledge of the medical, psychosocial, and other support services resources within the community, including their agency. It is the responsibility of the Peer Navigator to assist the client in navigating community resources, ensuring appointments are scheduled and attended, and services are continued. There will be times when a client has multiple concerns and needs that surpass the training and role of the Peer Navigator. Clients demonstrating or expressing needs outside the scope of the Peer Navigator training should be referred to the appropriate services to address those needs (for example, case manager, mental health provider, or health insurance expert) while still gaining the support of the Peer Navigator through the process.

Address barriers to initiating services

Individuals often want help, but are afraid to ask for help, have experienced negative interactions with providers, are unaware of the help available to them, or face challenges in life that make it difficult to seek, receive, or continue the help. Peer Navigators are responsible for identifying these barriers and working with the client to overcome them. Examples include discussing fears about taking HIV medications, helping clients secure transportation to appointments, or helping clients enroll in health insurance.

Liaise with health and other social service providers as needed

Peer Navigators support their clients in building an open, trusting relationship with their health care providers and other service providers, including their case manager, by helping them overcome transportation, communication, emotional, social, or other barriers to fully engage in care. The Peer Navigator may seek and share information and resources between the client's care team when the client provides consent. Throughout the process, the Peer Navigator models effective communication and resource navigation skills for their client, encouraging them to become competent in managing their own health and comfortable communicating service needs to the appropriate individuals.

Promote treatment adherence

Peer Navigators support client adherence to their HIV treatment and medication by working in collaboration with the care team. Peer Navigators can educate their clients on the importance of treatment adherence and the risks of non-adherence. Together, the Peer Navigator and client will develop a treatment adherence plan that may involve counseling, goal-setting, tips, suggestions, and personal strategies. Due to their shared lived experience with HIV, Peer Navigators are capable of providing practical advice on medication-taking, medication refills, medication initiation, clinical visits, options for obtaining medical care and treatment, side effect management, medication and appointment reminders, and other HIV-related care concerns.

Transport and accompany clients to HIV-related appointments

Peer Navigators are responsible for securing transportation for the clients to HIV-related medical appointments, when necessary (see page 23).

Provide guidance and emotional support

Living with HIV is not always easy. People living with HIV face stigma, discrimination, marginalization, and judgement from people who do not understand or are misinformed about HIV. In addition, many people living with HIV also experience racism, homophobia, transphobia, sexism, and religious or social marginalization. These negative experiences may be internalized by the person living with HIV and can and can then impact mental illness, risk-taking or feelings of hopelessness and loss of personal worth. The Peer Navigator should provide empathic support in a non-judgmental way to help alleviate such feelings, whether discussing concerns together or referring to counseling services.

Educate clients

Peer Navigators have valuable and unique perspectives to learn from and are equipped to provide basic HIV education to their clients. Clients should feel safe in asking questions regarding HIV or sharing personal experiences. Peer Navigators should dispel

any myths related to HIV or HIV treatment and help the client become more informed so they can make health decisions based on accurate information. It is important that the Peer Navigator also is aware of their own biases and can see the value of sharing both facts related to HIV treatment and their own lived experiences – both contain value in different ways.

Negotiating safer-sex and drug use harm reduction practices

Changing behaviors and achieving viral suppression can take time. During this journey, clients may be using less safe sex practices or using drugs. Peer Navigators can provide education and advice to their clients on safer-sex practices, pregnancy prevention and resources, STD prevention and treatment, and drug use harm reduction. It is important that the Peer Navigator remains non-judgmental and not force behavior change on their clients.

Competencies and Skills

Life experience with HIV

Peer Navigators must have life experience with the impacts of HIV and practice effective self-care strategies. Some Peer Navigators have made the decision to take charge of their health and well-being by initiating, accessing, and engaging in HIV care and treatment and have the experience of navigating through HIV care and supportive services. Some Peer Navigators have been significantly impacted by HIV and have experience with assisting others close to them living with HIV. Due to these experiences, the Peer Navigators must feel comfortable sharing personal stories and self-disclose, when appropriate, to support their clients.

Ability to work with diverse groups

Though Peer Navigators should reflect the community they are serving, not every client will share similar cultures, backgrounds, or beliefs as the Peer Navigator. Therefore, Peer Navigators must have strong interpersonal skills and a level of cultural humility that enables the Peer Navigator to provide high quality services to all clients with respect and compassion. It is important that Peer Navigators reflect on their own personal and cultural identity and how these characteristics influence their attitudes, beliefs, and assumptions.

Strong communication

Peer Navigators must have the ability to speak clearly, deliver information in a way that is accessible to a range of clients, and be capable of eliciting personal information from clients in a respectful manner. Through role modeling, Peer Navigators should demonstrate effective and assertive communication skills when discussing HIV care with providers that promote active self-advocacy from their clients. Peer Navigators

must be able to write clearly in order to provide thorough documentation of the services provided.

Advocate for one's self and others

Peer Navigators should be able to comfortably advocate for themselves, their clients, and for access to services even when organizational structures or processes are not supportive. Advocacy should be modeled in a professional manner that does not put themselves or the client in danger. The Peer Navigator must have the ability to embrace and communicate a positive, self-affirming, empowering attitude towards their clients and others living with HIV that promotes overcoming barriers such as stigma, fear, and hopelessness.

Trauma informed care

It is important that Peer Navigators understand the impact trauma has on a person's health, behaviors, relationships, work, school, and other aspects of life. Peer Navigators should take special caution not to re-traumatize their clients or themselves. An overview of Trauma Informed Care can be found on the DHS Trauma Informed Care website. The website includes webcasts and highlights the principles of Trauma Informed Care as well as resources.

Program Manager

The Program Manager is the primary supervisor of the Peer Navigators and the liaison between the Wisconsin HIV Program and funded agency. The Program Manager will also maintain a case load, comprising 20% of their time.

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 Navigators 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 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 introduce themselves through a phone-call or in-person to every client referred to the Peer Navigator Program. 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.

Communicate with Program Coordinator

The Program Manager is the primary contact between the State HIV Program and the funded agency. It is the responsibility of the Program Manager to provide the Program Coordinator 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 in-person meetings. The Program Manager must respond to all communication requests within 48 hours during regular business days. Program Manager must follow all program policies, procedures, and protocols outlined by the State HIV Program and the funded agency.

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 (6) months, the Program Manager will work with UniteMKE to ensure quality assurance, specifically as it relates to managing Care Coordination

Systems (CCS), the database in which the Peer Navigators' work will be documented. The Program Manager will be responsible for submitting quarterly reports to the Program Coordinator. **Quarterly Reports must be submitted as a PDF file via email no later than 5pm on the specified date** (See page 20 for more information).

Community Advisory Board

During the first year of Peer Navigator Program implementation, the Program Manager will be responsible for ensuring space is allocated for Community Advisory Board (CAB) meetings. CAB meetings will be held once every other month. CAB meetings will be scheduled out six months in advance. CAB membership should maintain 40% consumers and 60% providers, with a total of 8-12 members. The Program Manager will be responsible for co-facilitating the CAB meetings, in partnership with the Program Coordinator. During the meetings, the Program Coordinator will inform members of Peer Navigator Program updates and key dates. The Program Manager will provide members of program specifics, updates, and address any member concerns by involving stakeholders.

Competencies and Skills

The Program Manager will have the 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, Care Coordination Systems (CCS), and Microsoft Exchange
- 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

Referrals to the Peer Navigator Program

Summary

Referrals to the Peer Navigator Program may happen in four ways: external, internal, walk-ins, or through Data to Care.

External Referrals

An external referral is when a client is referred to the Peer Navigator Program 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 Referrals

Internal referrals happen when a staff member from the agency housing Peer Navigators offers the Peer Navigator Program to a client. Internal referrals maybe 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 agency directly to ask to participate in the Peer Navigator Program. 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.

Data to Care

The State may provide information to Peer Navigators of eligible individuals that have fallen out of care by accessing the Data to Care database. As a mandated reportable disease, specific data of a person living with HIV in the State of Wisconsin is collected and stored confidentially. This information may be used to locate an individual living with HIV in order to reengage them into HIV care and support. If this referral is made, it is the responsibility of the Peer Navigator to contact the person and attempt to re-engage them in care.

Follow-up on Peer Referrals to Other Services

"Referral follow-up" refers to how the Peer Navigator will determine if the client accessed the referral provided. Follow-up should be discussed with the client as part of the referral process. In most cases, this involves explaining to the client that the Peer Navigator would like to follow-up on the referral to ensure the client accessed services. Peer Navigators are prompted through CCS to determine if the referral was accessed and how the decision if confirmed.

Conducting referral follow-up provides the Peer Navigator an opportunity to assess and address barriers that may have prevented the client from keeping a referral appointment, assess their level of satisfaction with referral services, and assess additional referral needs.

There are four options for referral follow-up, including:

1. Active referral
2. Agency referral
3. Client verification
4. None

The options are defined as follows:

Active Referral

This option refers to when the Peer Navigator has directly linked the client to the referral source (service provider or agency). An example would be to arrange for a case manager to meet with the client at your site. Another example would be to attend the referral appointment with the client.

Agency Referral

This option refers to when the Peer Navigator contacts the referral agency to determine if the client accessed services. In this instance, the client agrees to the Peer Navigator following up with the referral source. For this to happen, the client must sign a Release of Information form detailing who and what information may be shared. With client authorization, the Peer Navigator can contact the client's case manager or linkage to care specialist to find out if and when the client accessed medical care and other services. Otherwise, the Peer Navigator must contact the medical clinic and other referral agencies to find out when or if the client accessed these services. A Release of Information must be

signed for each referral agency if obtaining information directly, rather than through the case manager.

Client Verification

This option refers to when the Peer Navigator follows-up directly with the client. In most cases, this is accomplished by scheduling a subsequent meeting with the client. Client verification may also take place over the phone. However, following up over the phone is less personal and less conducive to assessing additional referral needs. In addition, arranging for the client to contact the Peer Navigator is the least reliable method of follow-up. Agency staff can phone clients for follow-up but would need to ensure that it is done in a manner that does not breach client privacy or confidentiality. This may involve finding out from the client a preferred time to call, how to ensure the agency staff member is talking with the client rather than a third party, how to identify oneself if someone other than the client answers the phone, whether it is appropriate to leave a message, and whether to call from a phone that blocks caller ID. If leaving a voicemail, the Peer Navigator should be very careful to not leave confidential information on a message. **The Peer Navigator should only use their first name and never state the agency or reason for calling, and should keep the voicemail very general.**

None

This option refers to client refusal for follow-up. It is the expectation of the Wisconsin HIV Program that the Peer Navigator will attempt to follow-up whether a client has accessed a referral. However, this should not be done if the follow-up jeopardizes the linkage to the referral. For example, it is more important to link a client to medical care (either directly or through HIV case management services) than it is to insist a client allow the Peer Navigator to conduct referral follow-up if the client is hesitant to do so.

Caseload

Summary

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 ten 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.

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

The Patient Activation Measure (PAM) gauges client's readiness and ability to manage their own care by navigating healthcare systems and support services. Each client will complete a Patient Activation Measure at their first or second visit with their Peer Navigator. The first PAM is considered their baseline score. The Peer Navigator will complete the PAM with every client every three months to assess changes. **After a client has achieved a level 4 on two consecutive PAMs and the client attended referral appointments, the client has graduated from the program and may be closed out.** It is important that the Peer Navigator checks to see if referrals have been followed through prior to closing out their client, regardless of their PAM score. If a client achieves two consecutive level 4 scores on their PAM but has not attended referral appointments as planned, then the client should not be closed out. Instead, the Peer Navigator should address inconsistency with referral follow-through.

No Contact

Peer Navigators are required to follow up with their clients. If the Peer Navigator attempts to contact the client **at least once a month for 3 months** and does not hear from the client, the Peer Navigator must close out their case. It is best practice to attempt contact via different means (e.g. social media, home visit, texts, etc.) 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 **begins assessment from the beginning, following HIV Care Program HUB Protocols**. It is necessary for the client to complete all tasks as if they had never been a client before.

Appendix A: Consent to Follow-up

As a client receiving Peer Navigation services, I _____ understand that my Peer Navigator will follow-up on any referrals made to determine if I attended my appointment(s) and/or if I need additional support.

By providing my contact information on this form, I am giving my Peer Navigator permission to contact me using the below information. I understand that if any of the below information changes, I will inform my Peer Navigator. I understand that I may make changes to permission with a written request. I understand that a new Consent to Follow-Up Form may need to be signed if changes are made.

CONTACT INFORMATION							
Phone Number				**Type**	Home	Cell	Work
Text Allowed?	Yes	No		**Voicemail**	Yes No		
Phone Number				**Type**	Home	Cell	Work
Texts Allowed?	Yes	No		**Voicemail**	Yes No		
Social Media Accounts							
Facebook Messenger							
Instagram							
Snapchat							
Other							
Does someone else have access to your password?	Yes	No		Which accounts?			
Email							
Preferred Primary Contact (circle one) *Will always use first when contacting you*	Home	Cell	Work	Social Media	Email		

Client (Print Name)

Provider (Print Name)

Client Signature

Provider Signature

Date

Date

Appendix B: Authorization for Release of Confidential Information

By signing this form, I_____authorize you to release confidential health information about me by releasing a copy of my medical records or summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient/Client Name:_____Date of Birth: _____

I hereby authorize the following service provider to exchange information (which may be copied, orally communicated, or faxed) from my record with Diverse & Resilient:

Provider Name:_____Provider Affiliated Organization: _____

Provider Address: _____

Provider Telephone Number:_____Provider Fax Number: _____

The information you may release subject to this signed release form is as follows:

□ Complete Records
□ HIV Testing and HIV/AIDS Status**
□ CD4+/Viral Load**
□ Care Plan**
□ Pathology Reports
□ Hospital Reports
□ History & Physical
□ Treatment Record
□ Medication Record**
□ Progress Notes
□ Referral/Follow-Up**
□ Appointment Information**
□ Mental Health
□ Alcohol/Substance use
□ Operative Reports
□ Other (please specify)

**Initialing here is mandatory for all Peer Navigator Program clients

This authorization is valid until_____/_____/_____*(Date not to exceed 1 year)*

I acknowledge that I have fully reviewed and understand the contents of this form. I acknowledge that a photocopy or fax of this form is valid. I understand that I have the right to inspect and receive a copy of the information to be disclosed. I understand that I may refuse to consent to the release of the above information and that I may revoke this authorization at any time except to the extent action has already been taken. I understand that my consent is voluntary; however, my refusal may hamper further evaluation and care and will result in an inability to coordinate services with aforementioned agencies.

_____
Printed Name of Patient

_____
Signature of Patient

_____
Date

Appendix C: Client Agreement Form

As a client receiving Peer Navigation services, I_____commit to:

- Using language that is respectful towards staff and clients, and refraining from profane language.
- Respecting staff and clients by not using harassing, threatening, or assaulting behaviors.
- Not sharing personal information overheard or seen about other clients.
- Maintaining a safe space by not using or bringing any weapons on agency premises or on self when working with staff.
- Respecting personal boundaries and refraining from making sexual comments or gestures and sexually harassing any staff member or clients.

As a client receiving Peer Navigation services, I_____understand that:

- Services may be denied, rescheduled, or cancelled if informed consent is unattainable due to illicit drug or alcohol use.
- Services may be denied, rescheduled, or cancelled if my Peer Navigator or other staff feel threatened or uncomfortable.
- I may refuse services and participating in the Peer Navigator Program is voluntary and may be terminated with a written request at any time.
- I will follow grievance procedures and attempt to solve issues with my Peer Navigator together if I feel comfortable doing so.
- I will inform my Peer Navigator if my address, phone number or other contact information changes.
- My Peer Navigator will check-in with me regularly and will follow-up on referral appointments as agreed upon by my Peer Navigator and I.
- I will respect my Peer Navigator as a peer and as a provider and any other staff or client my Peer Navigator works with.
- During non-emergencies, I may contact my Peer Navigator during the Peer Navigator's designated time and will only contact them outside of those designated times when it is a crisis or emergency.

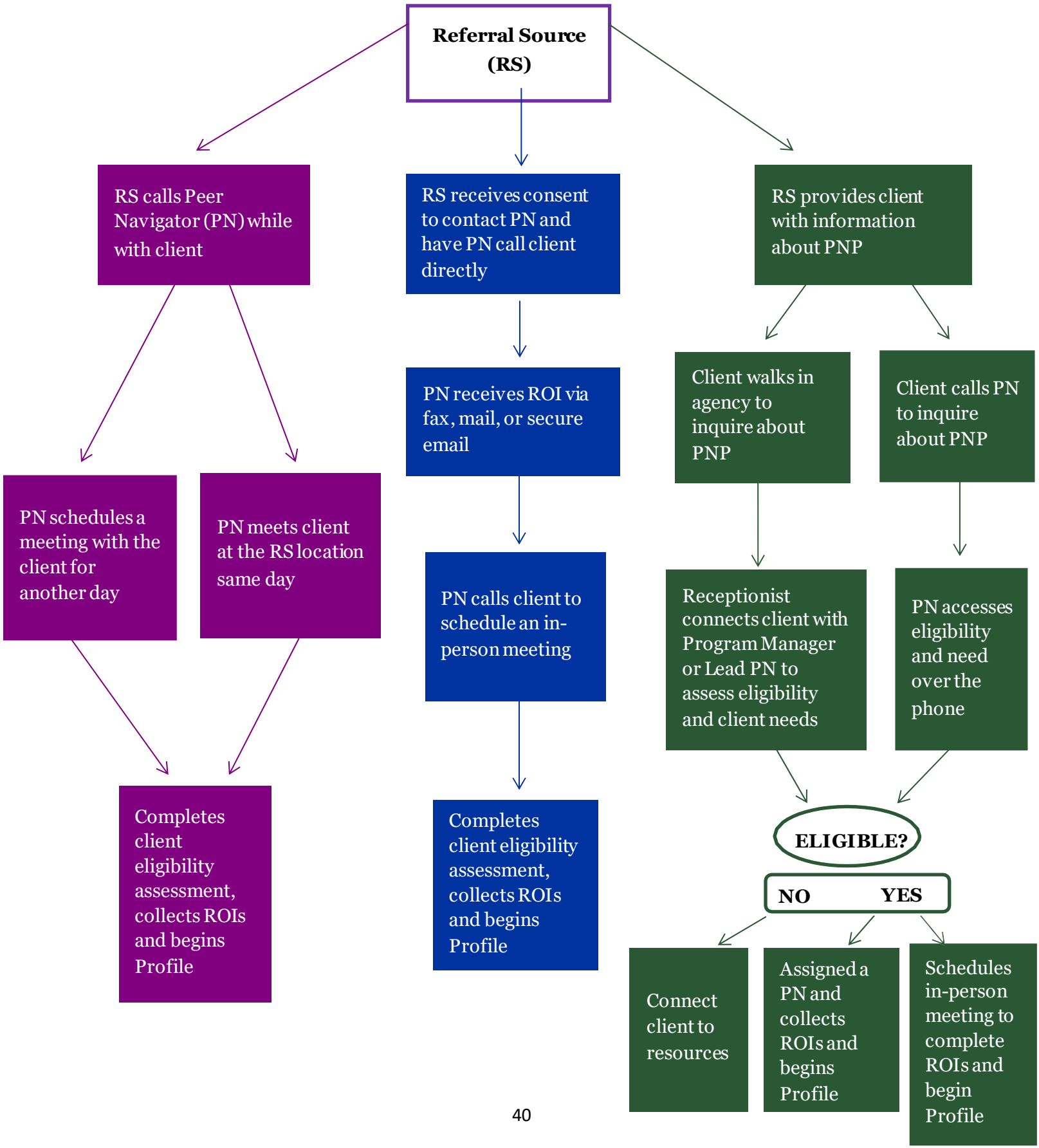
My Peer Navigator's designated time is:

M between _ _:_ _ AM and _____ PM
T between _ _:_ _ AM and _____ PM
W between _ _:_ _ AM and _____ PM
TH between _ _:_ _ AM and _____ PM
F between _ _:_ _ AM and_____ PM
SA between _ _:_ _ AM and_____ PM
SU between _ _:_ _ AM and_____ PM

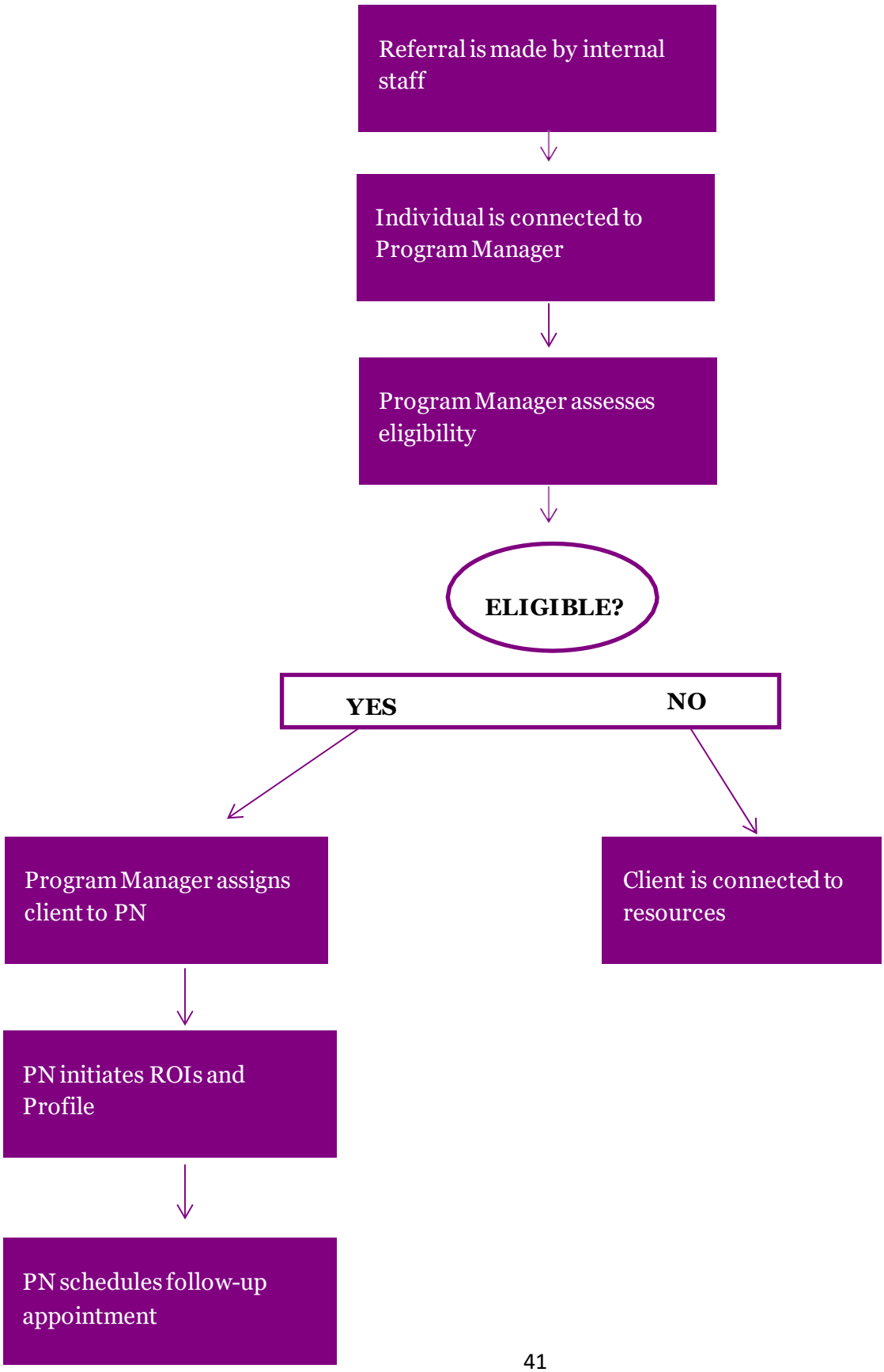
I understand my expectations as a client receiving Peer Navigation services and have taken the time to ask any questions I may have regarding this agreement.

Client (Print Name)	Provider (Print Name)
Client Signature	Provider Signature
Date	Date

Appendix D: External Referral Workflow



Appendix E: Internal Referral Workflow



Appendix F: HIV Care Program HUB Protocols

HIV Care Program HUB Protocols

Initial Visit

1. Signed **Consent/Release of Information (ROI).** Upload to Documents Tab. Do not enter information into the HUB software if Consent/Release of Information (ROI) is notsigned.
   - **Clinical Tool** Input information from last clinical information to include CD4 count and Viral load suppression
2. **PROFILE** Complete to 80% - important things to complete below
   - ***Client type***: Adult
   - Leave ***HUB client #*** and ***medical record number*** blank
   - **Relationship & Household Information** – make sure to enter an emergency contact; choose yes in "emergency" column for that person
   - **Programs** – HIV Care Program
   - **Insurance** - record "plan type" – Medicaid (if no insurance choose Uninsured) and "plan name"- United. "Plan number" comes from the Forward Health Portal or their card. When possible help client to call the number on the back of the card to find out their "renewal date". Medicaid as health plan is "primary" and covers "prescriptions" (click circles). Leave blank "Start Coverage", "End Coverage" blank. Use "Application Date" and "Confirm Date" for uninsured participants only (will be blank for most participants).
   - **Practice Group and Provider** -Select practice and then provider. If provider is not in the list – go to **Care Team -** select "provider" ; select "org/person" ; select add new. Leave the rest blank (Comm. Type, Comm. Address, HISP Name, Schedule, Next Send).
   - **Care Team** - In addition to the provider also add the names of any person or organization the woman is working with (Leave the rest blank (Comm. Type, Comm. Address, HISP Name, Schedule, Next Send)
   - **Status and Assignment**
     Active Status: "Active" (leave as is)

     Release of Information signed: "pending" if paper copy signed, "yes" if signed and uploaded into documents section *ROI Date*: Date client signed the consent/release *Enroll Status*: "assigned"; change to "enrolled" when **CONSENT** is uploaded**,** and **PROFILE,** and **INITIAL ADULT CHECKLIST** are 80% complete.
3. **INITIAL ADULT CHECKLIST** (Archive when completed – within 30 days)
   - Write Case Note at bottom of Checklist to summarize visit. Start with the date and end with your initials
   - Archive when complete (within 30 days)
4. Check Care Team Tab to see if the **PROFILE** and **INITIAL CHECKLIST** is 80% complete (hover over blue box with cursor)

Follow Visits - 1 month minimum check in post 2nd visit - any touch (physical or phone, etc.)

Every 2 months minimum - physical touch

1. Pathways –
    a. **Medication Assessment/Management** (Update every 3 months)
    b. **Education** – one per visit (https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets)
        - Appropriate use of healthcare
        - HIV Treatment Adherence
        - HIV Medicines
        - HIV and Diabetes
        - HIV and Pregnancy
            - Preventing Mother-to-Child Transmission of HIV
            - HIV Medicines During Pregnancy and Childbirth
            - Preventing Mother-to-Child Transmission of HIV After Birth
        - HIV and Hepatitis B
        - HIV and Hepatitis C
        - HIV and Nutrition and Food Safety

    c. **Medical Referral** to Self-Management workshop
    d. **Medical Home** if patient not connect to clinic (hasn't been seen in the last year)
    e. **Social Service Referral** and Social Determinants Pathways as appropriate**.** Major Pathways take longer **Housing, Employment, Adult Education, Smoking Cessation, Behavioral Health** (mental health or substance abuse)
2. Tools-

    Patient Activation Measure (PAM every 3 months) Client closed out/graduated from program after 2 PAMs have level 4 score and is correlated with referral follow through

    PHQ9

    Client Admit/Visit if client reports from WISHN data OR Client is admitted to ER/ED
3. **Adult Checklist**
    a. **Required:**
        - Next appointment date on bottom
        - Hospitalizations/emergency room visits
        - Start and end time

    b. **Note any changes since last visit**

    CHECKLISTS: START AND END TIME ADD "Archive" checklist and tools as complete.
4. Documents Tab
    a. Upload client lab reports and supporting documents

Appendix G: 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 people living with HIV 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 people living with HIV (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:

1. HIV infection, or for infants of indeterminate HIV status, proof that the mother is living with HIV.
2. 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]
3. Wisconsin residence.
4. Insurance coverage or proof of being underinsured or uninsured.

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

1. Low-income status.
2. Wisconsin residence.
3. 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 Documentation

	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 mother 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.

Definition of Family Income

To be eligible for Ryan White services, family income cannot exceed the designated level of FPL (e.g., 500% of FPL for HIV Care Grant services). Earned and/or unearned income received by any of the following individuals is counted toward overall family income:

- Client
- Client's legal spouse

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

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), and/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 web at https://aspe.hhs.gov/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 (i.e., use the same percentage of FPL to establish eligibility).
- There must be an application with supporting documentation (i.e., income andinsurance 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 H: Medical Transportation Log Instructions and Sample

Instructions: Complete one line for each instance of transportation assistance. For example, if you are providing 8 bus tickets to allow a client to attend 4 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 _____

*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.