

2014

LINKAGE CASE MANAGEMENT GUIDELINES

Division of HIV and STD Programs

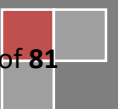


Table of Contents

ACKNOWLEDGEMENTS	3
INTRODUCTION/PURPOSE	4
What is Linkage Case Management?	5
How Does Linkage Case Management Differ from Traditional Non-medical Case Management (NMCM)	5
Table 1: Comparison of Linkage Case Management and Traditional Non-medical Case Management.....	5
GOALS AND OBJECTIVES.....	6
CLIENT ELIGIBILITY	7
PROCESS COMPONENTS.....	7
Diagram 1: LCM Process Components Flow Chart.....	9
THEORETICAL FRAMEWORK	10
Stages of Change (Transtheoretical) Model.....	10
Table 2: Processes of Change for Each Stage of Change.....	10
Strength-Based Service Delivery	12
Motivational Interviewing.....	13
OUTREACH.....	15
Table 3: Engagement in Care Continuum	15
Outreach Plan	16
BRIEF INTERVENTION SESSIONS	17
Table 4: Brief intervention activities that may take place during the five (5) session, ninety (90)-day period.....	18
Assessment	18
Table 5: A Strengths-Based Exploratory Process - Assessment	19
Linkage to Care Plan.....	23
Table 6: A Strengths-Based Exploratory Process – LTC Plan	23
S.M.A.R.T. Objectives	25
Linkage to HIV Medical Services	26
Behavioral Interventions.....	28
HIV Education.....	30
Risk Reduction Counseling.....	32
Disclosure Assistance	34
Monitoring	35
Intervention Extension.....	36
GRADUATED DISENGAGEMENT.....	37
FOLLOW UP	39
ADMINISTRATIVE REQUIREMENTS	40
Start Up Activities	40
Staff Development.....	40
Monthly Reports	41
Section I: Cover Summary Page	42
Section II: Demographic Information.....	42
Section III: Service Delivery Data	42
Section IV: Monthly Report Narrative.....	44
Report Submission	44
Performance Measures.....	45
Table 7: DHSP performance measures for LCM.....	45

Client Charts.....	45
File storage and retention.....	46
Maintaining Client Confidentiality	46
People Living with HIV/AIDS Bill of Rights & Responsibilities.....	47
Grievance Procedures.....	47
Works Cited	48
APPENDICES.....	52
Appendix A: Stages of Change	53
Appendix B: Motivational Interviewing Techniques	54
Appendix C: LTC Assessment	56
Appendix D: LCM Consent Form	63
Appendix E: Sample of LTC Plan Template	64
Appendix F: DHSP Intervention Extension Request Form	65
Appendix G: Graduated Disengagement Summary Form.....	66
Appendix H: Linkage Case Management Client Follow-Up Status Form	67
Appendix I: Flow Chart of Casewatch Client Registration and Data Entry Rules	68
Appendix J: Section IV: Monthly Report Narrative Form	69
Appendix K: Consent to Release Medical Information.....	70
Appendix K: Casewatch consent form in English	72
Appendix K: Casewatch consent form in Spanish	73
Appendix L: Sample Notice of Privacy Practices	74
Appendix M People Living with HIV/AIDS Bill of Rights & Responsibilities.....	80
Appendix N: Sample Grievance Procedures Notification Form	81

ACKNOWLEDGEMENTS

The following people were instrumental in assisting with the development of this guideline:

Angela Boger – Department of HIV and STD Programs
Wendy Garland, MPH– Department of HIV and STD Programs
Heather Northover, MPH – Department of HIV and STD Programs
Abel Alvarez – Department of HIV and STD Programs
Ana Rios - Department of HIV and STD Programs
Olga Padilla - Department of HIV and STD Programs
Alejandrina Juardo, MSW – Department of HIV and STD Programs
Patricia Wallace, MSW – Department of HIV and STD Programs
Carlos Vega-Matos, MPA – Department of HIV and STD Programs

INTRODUCTION/PURPOSE

HIV medical care and medication slows the progression of HIV, and is proven to reduce HIV-related morbidity and mortality among people living with HIV (PLWH) by preserving the immune system and encouraging viral load suppression. Unfortunately, successful linkage to and engagement in the HIV care continuum is a challenge both locally and nationally (Division of HIV and STD Programs, 2012); (Gardner E. M., 2011); (Hall, 2012); (Wohl A. T., 2009). Delayed linkage to and poor retention in HIV care limits treatment-as-prevention efforts and results in poorer health outcomes and survival (Cohen MS, 2011); (Crystal S., 2001); (Giordano T.P., 2007); (Giordano T.P. H. C., 2009); (Hall, 2012); (Mugavero, Lin, Willig, & et al, 2009); (Mugavero M. A., 2012); (Ulett, Willig, Lin, & et al, 2009); (Christopoulos, 2011); (Walensky, Paltiel, Losina, & et al, 2006).

Of the 1.1 million HIV-positive persons living in the US who are aware of their HIV status, it is estimated that 66% were linked to care, 37% are engaged in regular HIV care and 25% were virally suppressed (CDC, 2012). Data further suggests that those not in HIV care are disproportionately from marginalized populations and/or experience greater challenges in accessing care. They are more likely to be youth, women and racial/ethnic minorities, and have higher rates of being uninsured, are more likely to face barriers to medical care, and report higher rates of stigma and discrimination than other groups (Mugavero M. A., 2013); (Office of National AIDS Policy, 2013). In Los Angeles County (LAC), of the approximately 59,500 persons living with HIV/AIDS in LAC, including those who were unaware of their infection, an estimated 66% were linked to care within 90 days of diagnosis, 47% were retained in regular HIV care, and 45% were virally suppressed (Division of HIV and STD Programs, 2012). The gap between HIV diagnosis and engagement in HIV medical care indicates the need for greater investment in strategies to link and engage or re-engage PLWH in HIV medical services.

Nationally, increasing access to care and improving outcomes for PLWH remains a primary goal of the *National HIV AIDS Strategy*. The *Strategy* aims to increase linkage of newly diagnosed people to HIV medical care within three (3) months to 85% by 2015, and specifically identifies increased linkage to and retention in HIV care as strategies to improve prevention and treatment efforts (House, 2010). Of the many methods evaluated to engage PLWH in HIV care, evidence-based, case management approaches have been identified as successful strategies to link and retain HIV-positive persons in care (Higa, 2012); (Thompson, 2012). A brief, strengths-based case management program implemented in clinical and community-based sites linked 79% of newly diagnosed persons to HIV care; however, its utility has not been evaluated among persons who never accessed care or dropped out of care (Gardner L. M.-M., 2005); (Craw, 2008); (Craw J. G., 2010). A review of retention interventions reports that most were implemented in clinical settings and suggests that non-clinical settings, such as community-based organizations, are under-utilized to promote retention in HIV care (Higa, 2012).

To reduce the number of PLWH who are not in HIV care in LAC, Division of HIV and STD Programs (DHSP) is launching a coordinated effort to promote linkage to, and engagement in, HIV care. As part of this effort, DHSP has refined deployment of Non-medical Case Management services to focus on client access and linkage to HIV care for those who have been out of care for seven (7) months or more, and/or has not linked to HIV care since diagnosis within the last three (3) months or more.

LCM services are **a complement of—and should not replace—efforts by HIV testing service (HTS) providers and HIV medical providers** to link or re-engage their own clients, respectively. They are designed for clients who remain disengaged from HIV care following best efforts from their initial HIV testing or care provider(s) to link them successfully. LCM must not become an additional barrier to HIV care. HTS and HIV medical providers should reserve LCM referrals for clients with complex needs who clearly cannot link to HIV medical services on their own.

The HIV/AIDS Linkage Case Management (LCM) program consists of client-centered, strengths-based activities to facilitate linkage to HIV medical services through the process of outreach, brief intervention sessions, graduated disengagement, and follow up. These activities are conducted by trained Master’s-level Linkage Case Managers based at HIV service agencies in Los Angeles County.

This guideline is designed as a tool for Linkage Case Managers in Los Angeles County to support program implementation and promote uniformity and consistency in delivering Linkage Case Management to people with HIV/AIDS residing within Los Angeles County.

What is Linkage Case Management?

Linkage Case Management (LCM) is a time-limited, targeted approach to case management that focuses on identifying and linking PLWH to HIV medical care through the provision of brief interventions that increase access to, and readiness to engage in, primary HIV medical care. These activities are conducted by qualified Linkage Case Managers who assess a client's needs and strengths, and facilitate their access to HIV medical care, HIV risk reduction activities and other services that address immediate barriers to HIV medical care, including mental health and addiction treatment, and partner services’ third party partner notification. Note that all activities are designed with the ultimate and immediate goal of linking clients to primary HIV medical services. Coordination of, and linkage to, other psychosocial and socioeconomic services are done within the context of promoting engagement in primary HIV health care and reducing forward transmission of HIV and the acquisition of other STDs among clients.

Once clients are linked to HIV medical care, Linkage Case Managers fully disengage clients from LCM services. Clients are considered linked to HIV medical care after one HIV medical visit with an HIV medical provider, such as a medical doctor, nurse practitioner or physician assistant. **A prior appointment involving labs, clinic registration and/or an eligibility evaluation without an HIV medical provider visit does not qualify as a linkage to HIV medical care.**

How Does Linkage Case Management Differ from Traditional Non-medical Case Management (NMCM)

Linkage Case Management (LCM) primarily differs from traditional non-medical case management (NMCM) in that it is **short-term, transitional and specifically focused on linking clients to HIV medical care.** The intervention is **limited to a maximum of five (5) face-to-face brief intervention sessions** or until the client links to HIV medical care (whichever comes first), with all sessions **delivered within a ninety (90) day-period.** Once clients are linked, it is the expectation that HIV medical care sites will continue to promote optimal engagement in HIV medical care and HIV medication adherence. See Table 1 below for a side-to-side comparison of the two programs.

Table 1: Comparison of Linkage Case Management and Traditional Non-medical Case Management

	Linkage Case Management	Traditional Non-medical Case Management
Time Frame	Short-term: up to five (5) sessions within a ninety (90)-day period	Indeterminate sessions/time period
Purpose	Assists clients in linking to primary HIV medical care	Assists clients in obtaining medical, social, community, legal, financial, and other needed services to promote access, maintenance and adherence to primary HIV medical care
Service Delivery Setting	Where ever the client can meet (field case management)	Primarily in an office setting

Process Components	<p>Outreach</p> <p>Brief Interventions</p> <ul style="list-style-type: none"> ▪ Linkage to Care Strength-Based Assessment ▪ Linkage to Care Plan ▪ HIV Education ▪ Harm Reduction Activities ▪ Disclosure Assistance ▪ Behavioral Interventions ▪ Monitoring ▪ Linkage to HIV Medical Care <p>Graduated Disengagement</p>	<p>Outreach</p> <p>Comprehensive Assessment Service Plan</p> <p>Brief Interventions</p> <ul style="list-style-type: none"> ▪ Patient Education ▪ Harm Reduction Activities ▪ Disclosure Assistance ▪ Medical and Medication adherence Counseling <p>Monitoring</p> <p>Linkage to HIV Medical Care and other Social Services</p> <p>Client Transition</p>
Follow Up	One-time ninety (90) day follow up following graduated disengagement	Ongoing contact with the client. Frequency based on acuity
Case Conference	Not required	Once every 6 months
Clinical Supervision	Not required	Required
Staffing	Linkage Case Managers are required to have a master's degree in a social or human services-related field, such as psychology, social work, family therapy, counseling, etc.	Non-medical Case Managers are required to have a bachelor's degree in social or human services-related field, such as psychology, social work, sociology, counseling, etc.; OR a high school diploma or GED AND a minimum of 3 years' experience providing direct social services to clients within a medical setting or in the field of HIV/AIDS.

GOALS AND OBJECTIVES

The main goals of the Linkage Case Management (LCM) program are to use a time-limited, strengths-based case management approach to:

- Increase the number of out-of-care HIV-positive clients linked to HIV care; and,
- Increase the frequency of risk reduction activities to prevent the forward transmission of HIV and acquisition of other sexually transmitted infections (STDs).
- To link eighty-five (85) percent of clients to HIV care within ninety (90) days of initiating services; and

The goals will be achieved through the following objectives:

- To identify HIV-positive persons who are out of care through agency in-reach and collaboration with community service providers;
- To assess immediate needs, assets, priorities and barriers to accessing and engaging in HIV care for HIV-positive clients receiving LCM services;
- To deliver brief LCM services consisting of up to five (5) face-to-face sessions over ninety (90) days to facilitate linkage to HIV care; and
- To provide brief interventions to clients engaged in activities that promote the transmission of HIV

CLIENT ELIGIBILITY

Clients eligible for Linkage Case Management (LCM) include those who:

- Live in Los Angeles County;
- Are age 12 years or older;
- Are HIV-Positive; and
- Were diagnosed with HIV but never linked to HIV care within the last three (3) months or more prior to receiving LCM services; or
- Have accessed HIV medical care but have not had an HIV medical visit for seven (7) months or more prior to receiving LCM services.

An HIV medical visit is defined as a face-to-face visit with an HIV medical provider, including physicians, nurse practitioners, and physician assistants.

PROCESS COMPONENTS

Linkage Case Management (LCM) includes the following process components:

- **Outreach:** LCM programs work with agencies to identify and refer individuals living with HIV who are out of care to the LCM program. “Outreach activities” are defined as activities that:
 - 1) Educate HIV services providers and other supportive service organizations about the availability and benefits of LCM; and
 - 2) Develop relationships with agencies that can identify and refer eligible clients to the program.
- **Brief Intervention Session:** Consists of activities delivered to clients to promote readiness and linkage to primary HIV medical care. The intervention is delivered during **a maximum of five (5) face-to-face brief intervention sessions** or until the client links to HIV medical care (whichever comes first). Sessions should be a minimum of **one (1) hour per session** with all sessions **delivered within a ninety (90)-day period**. All activities during sessions must be executed using appropriate strength-based and motivational interviewing techniques to facilitate behavior change, which are grounded in social work theory and practice. Brief intervention activities include:
 - **Assessment:** A collaborative face-to-face conversation with the client during which the personal, social and environmental strengths, needs, priorities, and available resources are evaluated to identify interventions that will enhance readiness and facilitate immediate linkage to primary HIV medical care.
 - **Linkage to Care Plan:** The plan focuses on the goal of accessing HIV care and addressing psychosocial and structural barriers that prevent linkage to HIV care as identified during the assessment.
 - **Linkage to HIV Medical Services:** The goal of LCM is to link clients to HIV medical care through the implementation of brief intervention activities. Linkage Case Managers may link clients to HIV care whenever the client is ready to link to care within the ninety (90)-day intervention period. It is highly recommended that Linkage Case Managers accompany newly diagnosed clients to their first medical visit with the HIV medical provider, in order to provide support and ensure linkage.

Conduct the following behavioral interventions, including HIV education, risk reduction counseling, and disclosure assistance, as needed to promote HIV care linkage:

- **Behavioral Interventions:** Behavioral interventions address psychosocial issues identified in the Assessment that prevent linkage to HIV care, such as denial of HIV status, HIV stigma (internal or external), mental disorders, and substance use. While the likelihood of completely resolving some of these issues within the ninety (90)-day intervention period is small, the goal is to promote a change in the client's thinking and/or behavior that will directly lead to linkage to HIV care. Once in care, care coordination and other support staff at the clinic will continue to support the client in addressing client's ongoing concerns.
- **HIV Education:** HIV education increases client readiness to link to HIV medical care by assisting client in understanding the importance of HIV care and treatment. They may cover:
 - What is HIV;
 - How HIV is transmitted;
 - What HIV viral load and CD4 count measure and how it impacts their health;
 - Purpose of HIV medical care and medication; and
 - What to expect once they engage in HIV care.

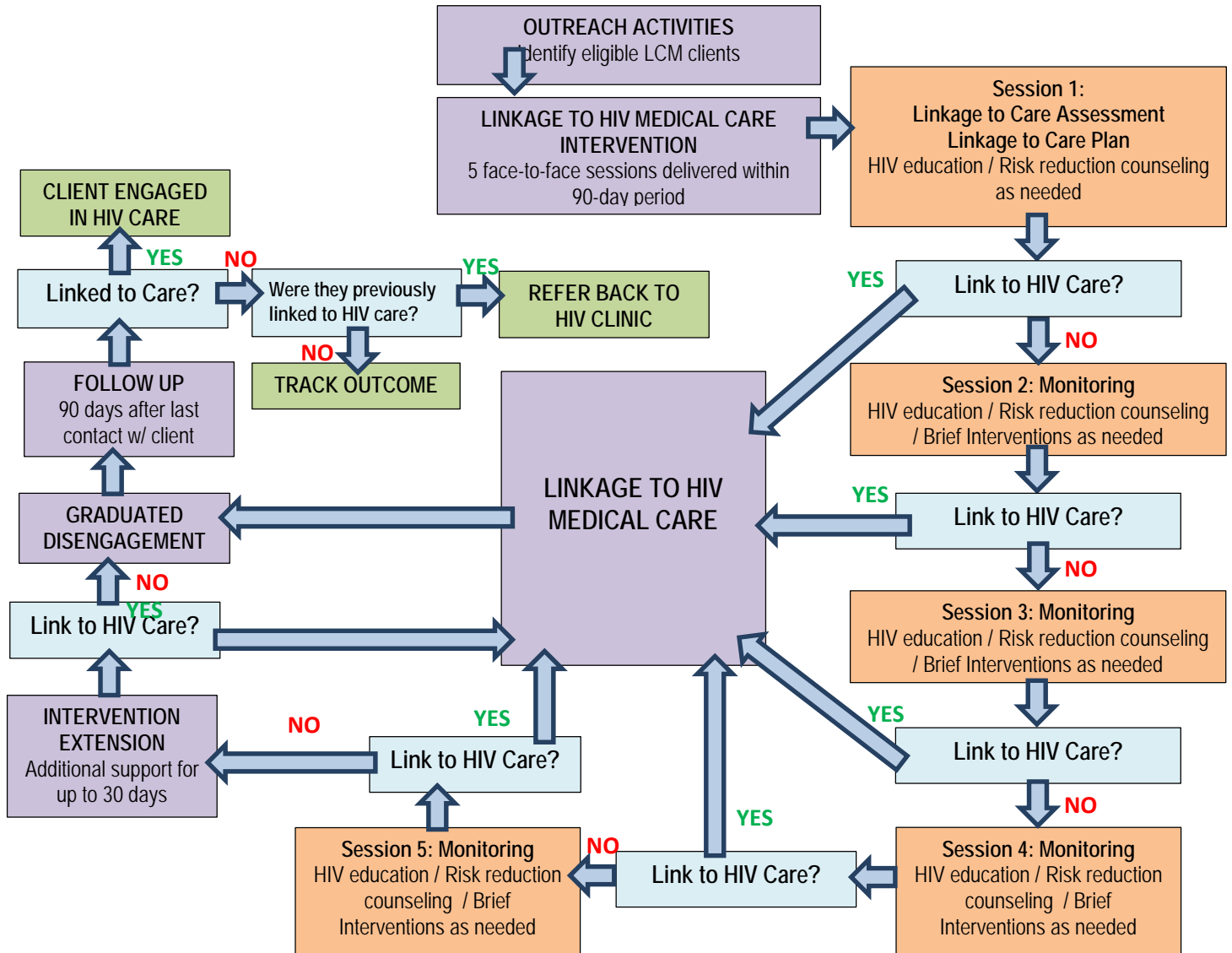
These sessions are not intended to provide specific information about treatment options or antiretroviral drug regimens but to prepare clients to engage in their HIV care.

- **Risk Reduction Counseling:** Harm reduction activities motivate clients to reduce their risk of transmitting HIV and/or acquiring other sexually transmitted diseases (STDs) through a variety of options that minimize their and their partner(s) exposure to HIV/ STDs.
- **Disclosure Assistance:** For clients who can benefit from disclosing their HIV status to a partner, family member or friend, in order to increase social support needed to assist linkage to HIV care.
- **Monitoring:** These activities involve ongoing contact with, or on behalf of, the client in order to achieve Linkage to Care Plan objectives, evaluate whether services are consistent with the needs of the client, and determines if any changes to objectives are necessary to assist the client's progress toward linkage to HIV medical care.
- **Intervention Extension:** An up to thirty (30) day extension that allows Linkage Case Managers to provide additional support to clients not yet ready to link to HIV care following the completion of the five (5) face-to-face sessions over the initial ninety (90) day-period. **The extension must be approved by DHSP.**
- **Graduated Disengagement:** Linkage Case Managers prepare clients to transition from LCM once they are linked to HIV care or after the five (5) sessions are over.
- **Follow Up:** A one-time contact with client **ninety (90) days** after they disengage from the LCM program. The follow up is designed to:
 - Ensure clients who were linked to HIV medical services remain engaged in HIV care; or
 - Provide an additional opportunity to link clients to HIV care for those who were not successfully linked during the initial intervention.

Each of these components will be discussed in greater detail in the guidelines. (If viewing the guidelines electronically, you may click on hyperlinks and it will take you directly to the corresponding section).

Diagram 1 below illustrates the expected flow of LCM process components during service delivery. Please note that linkage to HIV medical services may occur at nearly every point in the process, and once linked, graduated disengagement is completed. Additional intervention sessions with client become unnecessary following linkage to HIV medical care.

Diagram 1: LCM Process Components Flow Chart



THEORETICAL FRAMEWORK

LCM service delivery is rooted in the stages of change (transtheoretical) behavioral change model. Process components are delivered using appropriate strength-based and motivational interviewing techniques.

Stages of Change (Transtheoretical) Model

The Transtheoretical (also called the Stages of Change) model acknowledges that behavior change involves specific stages of readiness to change and that specific actions or processes are needed to move through these stages (Prochaska & DiClemente, 1982) (Prochaska, DiClemente, & Norcross, 1992). These stages include: precontemplation, contemplation, preparation, action, maintenance, and termination. (Sometimes people add relapse as a seventh stage to the cycle of behavior change.)



Providers assess the patient’s stage of change and use the transtheoretical model to guide their choice of appropriate interventions. To advance the patient’s progress most effectively, interventions are carefully stage-matched. The table below outlines stages of change descriptions and corresponding process of change:

Table 2: Processes of Change for Each Stage of Change

Stage	Readiness to change	Processes of Change
Pre-contemplation	Patient does not see behavior as a problem and sees no reason to change because: <ul style="list-style-type: none"> - lacks knowledge about the problem, or - tried to change in the past but it did not work and has given up on change 	<ul style="list-style-type: none"> -Increase awareness about the problem -Impact of patient’s behavior on others (what others’ impressions would be, or how affected by behaviors) -Pointing out discrepancies between the way the patient would like it to be and how it is
Contemplation	Patient recognizes a problem and is thinking about change but has not committed to it:	<ul style="list-style-type: none"> -Explore ambivalence by discussing pros and cons of change -Pointing out discrepancies between the way the

	-ambivalent about change -lacks confidence to change	patient would like it to be and how it is -Build confidence (self-efficacy) around change
Ready for Action	Patient has decided to change within the next 30 days: -has taken some behavioral steps in this direction	-Encourage commitment to change -Support self-efficacy to change -Develop a plan that considers strengths and deficits -Identify action goals for change
Action	Patient has changed behavior more than 1 day and less than 6 months	-Positive reinforcement for new behaviors – support self-efficacy -Identify immediate positive impact of behavior change on patient
Maintenance	Patient has changed behavior for more than 6 months	-Identify social support network members who can help support behavior change -Help patients identify and avoid cues to trigger old behaviors (relapse)

Adapted from Prochaska JO et al. 1997; Coury-Doniger, et al. 2000)

As a general rule, research has shown that for high-risk populations, 40% are in precontemplation; 40% are in contemplation; and 20% are in preparation for behaviors not yet adopted (Prochaska & Velicer, 1997).

Key principles of the Transtheoretical Model include:

- **Change occurs in steps over time.** Providers can assess what stage a person is at in relation to a specific behavior, and then focus on trying to move that person to the next stage using stage-specific and tailored interventions that are delivered over multiple contacts.
- **People are in different stages for different behaviors.** People are all in the process of changing many different behaviors at the same time. The Stages of Change model is very specific; it describes a person's relationship to changing a particular behavior (not a person's relationship to change in general). For example, it is very useful to recognize that a patient who doesn't want to access mental health services is pre-contemplative about seeking MH services. It would be inaccurate, however, to think of this person as simply pre-contemplative about all behavior change related to health because they may have different beliefs about related behaviors.
- **Different interventions work better at different stages.** One of the most powerful aspects of using this model is that different kinds of interventions tend to work better with different people, depending on what stage they are in. For example, "Contemplative" and "Preparation" usually respond best to verbal processes, focusing on insight, as well as education. Strictly behavioral interventions will be less successful at these stages compared to the "Ready for Action" and "Action" stages.
- **The stages of change are not linear.** People tend to move fluidly back and forth between stages. The pace of movement through these stages may vary greatly. Work with patients where they are and strategize ways to help them move forward, understanding that there may be movement between stages.
- **Relapse (or recycling) to earlier stages is always possible.** Once a person initiates a behavior change, that person is susceptible to relapse at any time and therefore may cycle back through the stages repeatedly. Think about that famous line from Mark Twain: "It's easy to quit smoking. I've done it hundreds of times."

Relapse is an important function of the stages of change and illustrates how this model is not a linear process. People may relapse/recycle back to any stage at any time, depending on the unique context within which they find themselves. Therefore, it will be important to explore what the relapse means to them and the context within which it occurred. In many instances, relapse (or recycling) can be seen as a learning opportunity to revisit the plan and explore what did and didn't work. This will primarily relate to those individuals who have dropped out of care.

- **Once an individual leaves the precontemplative stage, he or she will never again have the same capability for denial and avoidance.** Example: people in Alcoholics Anonymous sometimes say that AA can “really ruin your drinking.” Once someone attends an AA meeting, he or she will never feel the same about drinking—even if the drinking continues.

See [Appendix A](#) for additional information on Stages of Change.

Strength-Based Service Delivery

A strengths-based approach to service delivery does not ignore a client’s problems and difficulties, but seeks to identify the person’s resources and strengths that will 1) help address unmet needs by creating positive expectations that things can be different; and 2) open the way for the development of new knowledge, beliefs, attitudes and behavior change. This perspective views clients as “having potential,” as opposed to “at risk.” (Hammond, 2012)

The emphasis on strengths is founded on the following beliefs¹:

- All people have strengths and capacities
- People can change. Given the right conditions and resources, a person’s capacity to learn and grow can be nurtured and realized
- People change and grow through their strengths and capacities
- People are experts of their own situation
- The problem is the problem, not the person
- Problems can blind people from noticing and appreciating their strengths and capacity to find their own meaningful solutions
- All people want good things for themselves and have good intentions
- People are doing the best they can in light of their experiences to date
- The ability to change is within us – it is our story (Hammond, 2012).

The following are principles² that serve as the foundation for guiding and implementing strengths-based practice:

- Every person has potential and it is their unique strengths and capabilities that will determine their evolving story. Avoid defining people by their limitations.
- What we focus on becomes one’s reality. Focus on strength, not labels. Seeing challenges as a way to foster capacity creates hope and optimism.

¹ The following were cited as sources for the strength-based beliefs by the referenced document:

Avord, M.K., and Grados, J.J. (2005). Enhancing resilience in children: A proactive approach. *Professional Psychology: Research and Practice*, Vol. 36(3), 238-245.

Rapp, C. and Goscha, R.J. (2006). *The Strengths Model: Case Management with People Suffering Severe and Persistent Mental Illness*. New Year: Oxford Press.

² The following were cited as sources for the strength-based principles by the referenced document:

Rapp, C. and Goscha, R.J. (2006). *The Strengths Model: Case Management with People Suffering Severe and Persistent Mental Illness*. New Year: Oxford Press.

Sharry, J. (2004). *Counselling children, adolescents and families: A strength-based approach*. London: Sage Publications.

- Believe that change is inevitable. All individuals have the urge to succeed, to explore the world around them, and to make themselves useful to others and their communities.
- Positive change occurs in the context of authentic relationships. People need to know someone cares and will be there unconditionally for them. It is a process of supporting change and capacity building – not fixing.
- A person’s perspective of reality is primary. Value and start the change process with what is important to the person.
- People have more confidence and comfort to journey to the future when they are invited to start with what they already know.
- Capacity building is a process and a goal, a life-long journey that is dynamic as opposed to static.
- It is important to value differences and the essential need to collaborate. Effective change is a collaborative, inclusive and participatory process.

(Hammond, 2012)

For more information, go to [A Strengths-Based Perspective by Wayne Hammond and Rob Zimmerman](#).

Motivational Interviewing

Motivational interviewing (MI) is a more directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence (Rollnick, 1995). It is more focused and goal-directed than some other patient-centered approaches. The examination and resolution of ambivalence is its central purpose, and the provider is intentionally directive in pursuing this goal. This method is best utilized when a patient is in the contemplative stage of change and may be an effective tool to move the patient forward in their progress. However, MI techniques can be useful at every stage of change.

The basic principles of MI are similar to the Transtheoretical Model and involve:

- Assessing the patient's readiness or willingness to change
- Using specific techniques to move people toward change based on their present state of willingness
- Assisting the patient in creating a favorable climate for change to occur
- Exploring, addressing, and, to an extent, resolving ambivalence and resistance

Motivational interviewing is characterized by the following beliefs:

- Readiness to change is not based on who a patient is but where the patient is in his/her readiness to change. Avoid seeing resistance and denial as patient traits, but as cues to modify motivational strategies.
- Ambivalence is the largest obstacle to change. Ambivalence stems from a conflict between two courses of action (e.g., indulgence versus restraint), each of which has perceived benefits and costs associated with it. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in a patient-centered and respectful atmosphere.
- The patient, rather than the provider, must articulate and resolve their ambivalence. A patient needs the opportunity to explore the often confusing, contradictory and uniquely personal aspects of their conflict. The provider's task is to facilitate this cost-benefit analysis, and to guide the patient toward a resolution that triggers change.
- Direct persuasion, aggressive confrontation, and argumentation are not effective methods for resolving ambivalence. These tactics often encourage the patient to defend the status quo, thereby increasing resistance to change.

When practicing motivational interviewing:

- 1) Explore both sides of the status quo or keeping things as they are. Start with good things about the status quo; then ask about the problems or potential problems.
- 2) Accent the positives of change. The more patients talk about changing behavior and hear their own reasons to change reflected back, the more likely they are to change.
- 3) Recognize when the balance tips toward positive change. Once it becomes clear that the patient wants to make a change, summarize the motivation towards change, discuss options for change, and support the patient's commitment, confidence and ability to change.
- 4) Roll with resistance. Resistance is defined as a patient's refusal to look at change behavior. View encountering resistance as an opportunity to reevaluate and adjust motivational strategies.
 - a. Monitor the patient's degree of readiness to change, and ensure that resistance is not generated by pushing the patient too hard or fast toward change.
 - b. Use active listen skills, such as parroting, paraphrasing and reflection to demonstrate the patient is being heard, such as "So you are saying/feeling that..."
 - c. Use double-sided reflections to link their resistance to previous, contradictory statement that the client has made.
 - d. Affirm the patient's freedom of choice and control.


See [Appendix B](#) for more information on motivational interviewing techniques.

OUTREACH

Of the people living with HIV who knew their status in Los Angeles County at the end of 2011, as many as 13,915 (32%) were out of care in the county that year.³ There is also a broad spectrum of HIV care engagement, ranging from those who have never entered HIV care to patients consistently engaged in care. While the goal is a linear progression toward on-going retention in primary HIV medical care, many PLWH typically cycle through or transition among the different stages in the continuum of care, which can contribute to suboptimal health outcomes) (Rajabiun, 2007); (Health Resources and Services Administration, HIV/AIDS Bureau, 2006). Below is a table illustrating the Engagement in Care Continuum from the Health Resources and Services Administration (HRSA).

Table 3: Engagement in Care Continuum

Not in Care			In Care		
Unaware of Status (not tested or never received results)	Know HIV Status (not referred to care or didn't keep referral)	May be Receiving Other Medical Care but not HIV Care	Entered HIV Primary Medical Care but Dropped Out (lost to follow-up)	In and Out of HIV Care or Infrequent User	Fully Engaged in HIV Primary Medical Care



(Health Resources and Services Administration, HIV/AIDS Bureau, 2006)

Conducting outreach activities is essential to identifying individuals not fully engaged in HIV medical care along this continuum from “know HIV status” to “in and out of HIV care/infrequent users.” Potential pools of eligible Linkage Case Management (LCM) clients include, but are not limited (or mutually exclusive) to:

- Newly diagnosed HIV-positive clients from HIV testing services (HTS) programs who were not yet linked by HIV care by HTS staff within three (3) months of diagnosis;
- HIV clinic patients who have disengaged from community-based clinic, Department of Health Services (DHS) or managed care site(s) for seven (7) months or more;
- Recently released, post-incarcerated HIV-positive individuals not in HIV care⁴;
- HIV-positive individuals receiving social services not in HIV care; and
- HIV-positive partners of HIV-positive individuals not in HIV care.

Clients already linked to HIV care and seen by an HIV medical provider within the last seven (7) months are ineligible for LCM and must be referred back to their system of HIV care for additional support through existing care coordination services offered at the medical care site.

“Outreach activities” for LCM programs are defined as activities that:

- Educates HIV services providers and other supportive service organizations about the availability and benefits of Linkage Case Management (LCM); and
- Develops relationships with agencies that serve a similar target population and that can identify and refer eligible clients to the LCM program.

³ Unpublished data from HIV surveillance, Division of HIV and STD Programs (2014).

⁴ PLWH in incarcerated settings do receive HIV medical services while in jail or prison but services are automatically disrupted upon release.

This entails marketing to and working in collaboration with, but not limited, to:

- HIV testing venues;
- Health education/risk reduction (HE/RR) programs;
- HIV primary health care centers and clinics;
- HIV support service providers; and
- Other organizations and institutions serving HIV-positive clients who are not linked to HIV medical care, i.e., non-traditional partners

to support successful outreach and community partnerships. **The program is not designed for client-based outreach methods.**

When Linkage Case Managers conduct outreach activities, they should track time spent conducting outreach activities in Casewatch by entering time under “Outreach” in the Casewatch LCM module. Time spent conducting outreach activities is tracked and included under the “Number of Service Hours: Outreach” column in the monthly report and count toward the program’s goal for number of service hours.

Outreach Plan

As part of a cogent outreach strategy, all LCM programs are required to develop an outreach plan for review and approval by DHSP. The plan is due within ninety (90) days of the program’s start (June 30, 2014). The plan should include:

- a. A brief description of all linkage to care (LTC) programs and efforts offered at the agency. This may include, but is not limited to, programs supported by CDC, HRSA, DHSP, and agency discretionary funds;
- b. How the agency plans to coordinate and limit duplication of services among agency’s linkage to care programs;
- c. Description of LCM’s target population;
- d. What strategies the program will employ to recruit eligible program participants;
- e. A list of referral sources and partner agencies;
- f. Copies of MOUs with partner agencies;
- g. How the program will document and monitor the number and types of contacts that were initiated to establish new referral sources and partnerships; and
- h. An evaluation plan for outreach efficacy, including tracking how clients are being referred to the LCM program.

When developing the outreach plan, complete the following activities:

- 1) **Identify and describe the program’s target population.** Examine your agency’s assets and the types of clients your agency typically serves and successfully engages.
- 2) **Research the target population’s unique characteristics and geographic location(s),** in order to target outreach efforts effectively.
- 3) **Identify organizations and other institutions that serve your target population or provide services near where they live/play** as potential referring partners. Expand beyond the scope to traditional HIV service providers.

- 4) **Cultivate relationships with the agencies that might be sources of client referrals.**
Meet with agencies and establish formal or informal MOUs.
- 5) **Develop and submit an LCM Outreach Plan** for DHSP approval.

BRIEF INTERVENTION SESSIONS

Studies show that passive referrals to HIV care following diagnoses at testing sites, particularly when delivered in nonmedical settings, are correlated with delayed or unsuccessful linkage to HIV medical services (Mugavero M. A., 2013). The primary goal of Linkage Case Management (LCM) is to link clients into HIV medical care by providing an additional level of support needed to ensure linkage. Depending on the client's need(s), service intensity and length of engagement will vary. In fact, clients may link to HIV care at any point during the series of brief intervention sessions and may not require the entire five (5) sessions, ninety (90)-day intervention prior to HIV care linkage. In a similar LCM model, clients, on average, had 2.6 sessions during the intervention (Gardner, 2005).

All LCM activities are conducted with the lens of increasing a client's capacity to link to HIV care. This means addressing the client's immediate barriers to successful linkage by enhancing the client's own strengths, skills and resources, and working with care coordination staff at the HIV medical site as needed, in order to provide client with ongoing support to remain engaged in HIV care.

The following brief intervention session components facilitate a client's capacity to link to HIV medical care by enhancing the client's ability to resolve of barriers to HIV care. The intervention focuses on addressing factors identified through a brief Assessment that will increase readiness and assists the client in addressing underlying attitudes, beliefs and/or practices that hinder linkage to HIV care and risk reduction behaviors. The intervention is delivered during **no more than five (5) face-to-face brief intervention sessions** or until the client links to HIV medical care (whichever comes first). Sessions should be a minimum of **one (1) hour per session** with all sessions **delivered within a ninety (90)-day period**. All activities during sessions must be executed using appropriate behavior change counseling skills and strategies grounded in behavioral theory, social work practice and techniques. Brief intervention activities include:

- [Assessment](#)
- [Linkage to Care \(LTC\) Plan](#)
- [Linkage to HIV Medical Services](#)

As needed to promote HIV care linkage:

- [Behavioral Interventions](#)
- [HIV Education](#)
- [Risk Reduction Counseling](#)
- [Disclosure Assistance](#)
- [Monitoring](#)

Each of these components will be discussed in greater detail below. (If viewing the guidelines electronically, you may click on the hyperlink and it will take you directly to the corresponding section).

The first of the five (5) face-to-face brief intervention sessions allowed will typically cover the Assessment and LTC Plan. Subsequent sessions will include monitoring activities and behavioral interventions, including HIV education, risk reduction counseling and disclosure assistance as needed to further motivate clients to link to HIV medical services. Linkage to HIV care can occur at any time within in the 90-day intervention period.

Below is a table that illustrates when the brief intervention activities may occur over the span of the five (5) sessions, ninety (90)-day period.

Table 4: Brief intervention activities that may take place during the five (5) session, ninety (90)-day period

Brief Interventions	Session 1	Session 2	Session 3	Session 4	Session 5
LTC Assessment	X				
LTC Plan	X				
Linkage to HIV Care	X	X	X	X	X
AS NEEDED FOR TO PROMOTE LINKAGE:					
Behavioral Interventions		X	X	X	X
HIV Education	X	X	X	X	X
Risk Reduction Counseling	X	X	X	X	X
Disclosure Assistance		X	X	X	X
Monitoring		X	X	X	X

90-Day Period

Assessment

Whether or not clients immediately link to HIV care may be determined by common themes affecting client engagement in HIV medical care, such as level of acceptance of HIV, coping with substance use, mental health and stigma, health care provider relationships, presence of external support, and ability to address external barriers to HIV care (Rajabiun, 2007). The Assessment allows the Linkage Case Manager to explore with the client these and other complex issues affecting successful linkage to HIV care. Understanding what factors affect each client, and how they help or hinder the client’s motivation or ability to access HIV medical services, outlines next steps needed to support client linkage to in HIV care.



The Assessment is conducted through a face-to-face interview between the Linkage Case Manager and client using a brief, countywide standardized assessment tool programmed in DHSP Data Management System. The assessment evaluates the client’s psychosocial needs, assets and priorities to HIV care. This includes:

- HIV Testing and Care History;
- Barriers to HIV Medical Care;
- Mental Health Status;
- Substance Use;
- Sexual Risk Behaviors; and
- Housing Status

Client responses to the Assessment guide the delivery of subsequent LTC activities. See [Appendix C](#) for a copy of the assessment.

Please note, while the assessment is designed to record and track factors that primarily hinder linkage to HIV medical care, **delivery of the assessment process when working with a client should remain strength-based**. The following table illustrates a strength-based exploratory process by which the assessment may be conducted effectively as outlined in the first three highlighted columns (“Stories and Challenges,” “Picture of the Future,” and “Strengths and Exceptions”).

Table 5: A Strengths-Based Exploratory Process - Assessment

Stories and Challenges	Picture of the Future	Strengths and Exceptions	Other Resources	Plans and Next Steps
Ask questions that invite people to share their stories and enable them to clarify the challenges.	Ask questions that help people explore their aspirations, dreams, interests, and goals.	Ask people that help people explore their strengths and the exception to the challenge.	Ask questions that help the person identify resources that might help them reach their goals.	Ask questions that enable people to specify concrete steps towards their goals.
What's happening? How do you feel about this? How long has this been a concern for you?	What do you want to be happening instead? What will it look like when this challenge is addressed?	What strengths do you have that might be helpful? What do you do well?	Who else might be able to help? What other skills and resources might be helpful?	What steps can be taken given your picture of the future, strengths and resources? Who will do what? When? How? By when?
How is it affecting you and others?		What is happening when the challenge is not present?		

from *A Strengths-Based Perspective* (Hammond, 2012)

As Linkage Case Managers, follow the steps below when completing an Assessment with a client during the first face-to-face brief intervention session:

- 1) **Determine how client was referred to program.**
- 2) **Assess whether the client is eligible for services.** Confirm that the client is:
 - a. HIV+;
 - b. Lives in Los Angeles County;
 - c. 12 years of age or older;
 - d. Has not been in HIV care in the last seven (7) months or more, and/or has not linked to HIV care since diagnosis within the last three (3) months or more; and
 - e. Does not already have an HIV care appointment scheduled.
- 3) Once a client agrees to participate in the LCM program, **complete client registration and consent.** This includes:
 - a. Documentation of HIV diagnosis. This may include a confirmed HIV test result with their name for newly diagnosed individuals or an HIV diagnosis form or HIV lab report for individuals who have previously been in HIV care.
 - b. Proof of Los Angeles County Residence. This may include a *current* California-issued identification; piece of official mail; and/or rental agreement with their name and a Los Angeles County address.
 - c. Confirmation from client that they have not received HIV care services within the last 7 months.
 - d. Signed consent to receive LCM services. See [Appendix D](#) for a sample copy of the LCM consent form.
 - e. Signed Casewatch consent form.
 - f. Intake form that lists client name, home address, mailing address, and telephone number; emergency and/or next of kin contact name, home address, and telephone number;
 - g. A signed and dated Release of Information, which is compliant with the Health Insurance Portability and Accountability Act (HIPAA); and

- h. A signed and dated Limits of Confidentiality in compliance with State and Federal Law.

In cases when clients do not have documentation verifying HIV diagnosis or County of Los Angeles residence, Linkage Case Managers should assist the client in obtaining the eligibility documentation as part of the intervention and may provide LCM sessions in the interim. Lack of documentation should not be a barrier to service delivery.

Please note, subsequent service delivery data cannot be entered into Casewatch until the client's registration is completely entered into Casewatch. Registration is considered complete once registration eligibility fields 1 through 4 are entered with the client's information into the system.

- 4) **Initiate the Assessment** following program registration and intake. If the client is unable to stay for the assessment, schedule a day, time and location to complete the assessment with the client at their earliest convenience within the next **two (2) weeks**.

If you and the client plan to conduct the assessment off-site in the field, ensure the location is appropriate for having a private conversation.

- 5) **Frame the purpose and reason for the Assessment.** Let the client know that this process is designed to understand their knowledge of, and past experiences with, HIV medical care (if applicable) and client readiness in terms of accessing HIV medical care. This includes assessing the things in their lives that are pushing them toward or pulling them away from seeking HIV medical care. Also let them know that you may be taking notes from time to time and/or using a form to capture the information they share with you. Assure them that these notes are kept confidential.
- 6) **Reiterate limits of confidentiality and your role as a mandated reporter** (if applicable⁵). Ensure the client understands what they share is confidential unless they inform you of suspected abuse or neglect of a child or dependent adult, suicide ideation and/or homicidal intent.

The following is some suggested language regarding explaining limits of confidentiality:

Anything you say about sex, drugs and feelings is confidential unless you give me permission to share it.

But if you tell me:

- ✓ *A child or dependent adult is being abused (physically and/or sexually)*
- ✓ *You are going to hurt yourself or someone else*
- ✓ *You are 21 years or older and having sex with someone under 16*

I AM REQUIRED TO REPORT THIS INFORMATION.

- 7) **Begin a collaborative dialogue with the client** and collect the necessary information that covers the primary domains in the Assessment. It is important to assess whether each domain is an immediate barrier to HIV medical services, and how the different domains interact to minimize or compound barriers to HIV care and the transmission or acquisition of HIV/STDs. The domains include:

⁵ There is a list of 33 mandated reporters, but those pertaining to adolescent health services are: 1) Physicians, 2) Surgeons, 3) Psychiatrists, 4) Psychologists, 5) Psychological Assistants, 6) Mental Health and Counseling Professionals, 7) Dentists, 8) Dental Hygienists, 9) Registered Dental Assistants, 10) Residents, 11) Interns, 12) Podiatrists, 13) Chiropractors, 14) Licensed Nurses, 15) Optometrists, 16) Marriage, Family and Child Counselors, Interns and Trainees, 17) State and County Public Health Employees, 18) Clinical Social Workers, 19) EMT's and Paramedics, and 20) Pharmacists

a. HIV Testing and Care History

Understanding the client's HIV testing and care history gives a sense of "where the client is at" in terms of readiness to link to HIV care. Insight into the client's experience and any relationship(s) with past HIV provider(s) will better prepare you for the linkage to HIV care process, including whether the client may be better served at a new HIV care site.

b. Barriers to HIV Care

A myriad of cognitive (knowledge, expectations, and attitudes), behavioral (skills, practice and self-efficacy) and environmental factors prevent clients from seeking or sustaining regular HIV care. These include, but are not limited to, competing life needs and priorities, denial of HIV status, lack of access to HIV care, mental disorders, poor healthcare provider relationships, substance use and socioeconomic concerns (Health Resources and Services Administration, 2011); (Rajabiun, 2007). Because some of these issues are frequently cited as barriers to HIV care, they are explored in their own separate assessment domains, including mental health, substance use and unstable housing.

c. Mental Health

Between one third and one half of PLWH suffer from a current mental disorder, which can have a profoundly negative impact on HIV care utilization on its own or as an antecedent to drug use (Klinkenberg, 2004). In one study, fifty-seven (57) percent of those not in HIV care reported having an unmet need for mental health care as compared to thirty-seven (37) percent of those in care (Health Resources and Services Administration, HIV/AIDS Bureau, 2006).

If client indicate that they are a danger to self or others, contact a supervisor and conduct crisis intervention, referring for immediate evaluation as needed.

d. Drug Use

Substance use is a strong predictor of disengagement from HIV care and a major barrier to HIV care during the first year following an HIV diagnosis (Health Resources and Services Administration, HIV/AIDS Bureau, 2006). Clients out of care also report more unmet need for substance abuse treatment (Health Resources and Services Administration, HIV/AIDS Bureau, 2006). Additionally, the potential relationship between substance use and unsafe sexual behaviors highlights the need for a comprehensive assessment of alcohol and drug use.

e. Housing

Competing life concerns, such as unstable housing, can overwhelm clients and take priority over HIV care. In one study, clients described how homelessness and unstable housing directly led to gaps in HIV care (Rajabiun, 2007).

f. Sexual Risk Behaviors

Out-of-care client populations report higher rates of unprotected sex than those in care, which places them at risk for HIV transmission and acquisition of other STDs (Health Resources and Services Administration, HIV/AIDS Bureau, 2006).

- 8) **Use empathy and your communication skills to elicit important information;** avoid reading the form verbatim or simply covering the questions in a Q&A approach. The assessment is simply a tool to record notes and trigger important topics for discussion. Areas not explicitly addressed on the assessment tool may be explored if deemed important to the intervention and/or the client's inability to access HIV medical services.

Do not give the assessment form to clients to complete on their own. The process of completing the assessment with the client is critical for you to successfully and appropriately deliver LCM services.

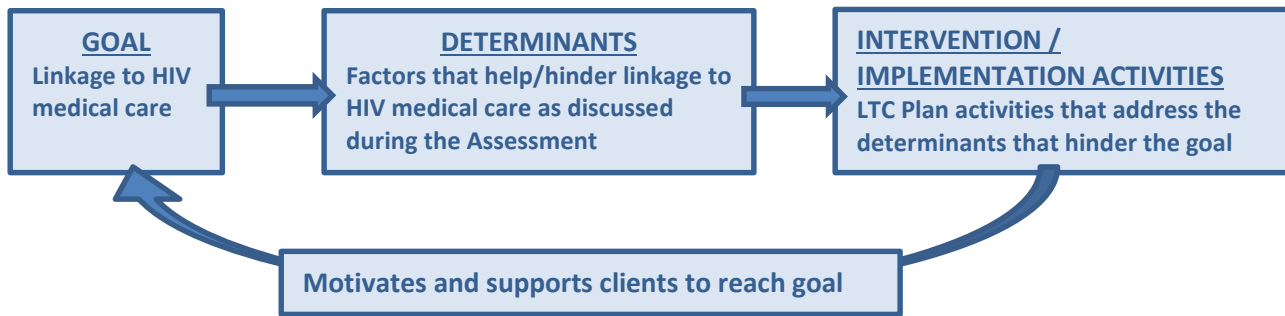
Some additional tips when completing the assessment are below:

- Although the domain topics are presented in a specific order on the assessment, they do not have to be addressed in that order during the session. Allow the conversation to develop organically, focusing on the client. You may also choose to begin the conversation with topics that may seem less invasive and/or threatening to the client. Avoid potentially stigmatizing topics until rapport with the client is established.
 - Use a strength-based approach. Acknowledge positive behaviors and attempts to change risk behaviors. Avoid focusing on deficits.
 - Reinforce assets and positive relationships.
- 9) **Seize opportunities to motivate the client to access HIV care when they occur** during the conversation. Highlight any “a ha!” moments related to the importance of seeking HIV care. Constructively explore cognitive dissonance.
- 10) When you and the client are ready to conclude the conversation, **review the Assessment tool to ensure all areas were addressed.** Follow up on any missed items.
- 11) **Provide a brief summary of main points** to ensure the information heard was correct. It is also recommended to highlight times in the conversation when the client shared factors (cognitive, behavioral or environmental) that affect (either help or hinder) his or her readiness to link to HIV care. Empathize with their concerns and challenges but also emphasize their stated reasons or abilities to access HIV care.
- 12) **Transition to Linkage to Care Plan development.**
- 13) **Following the session with the client:**
- a. **Document a summary of the assessment in your progress notes** and file in the client’s chart. Include the date, time spent conducting the assessment, client’s strengths and barriers to HIV care, as well as any other relevant observations.
 - b. **Ensure data from the Assessment tool is entered into Casewatch within two (2) weeks** of the assessment’s completion. **Subsequent service delivery data cannot be entered into Casewatch until the client’s assessment is entered into Casewatch.**
 - c. **Track time spent conducting the Assessment with client in Casewatch.** Time spent documenting an assessment summary and entering assessment data into Casewatch is considered part of time spent conducting the assessment. This means if a provider spent 45 minutes conducting the assessment, 15 minutes documenting an assessment summary and 15 minutes entering assessment data into Casewatch, they may enter 1 hour and 15 minutes under “Baseline Assessment” in the Casewatch “Client Service Encounter” screen for the LCM module.

Time spent conducting the Assessment is tracked and included under the “Number of Service Hours: Interventions” column in the monthly report.

Linkage to Care Plan

The primary goal of LCM is to link the client to HIV medical care. The Linkage to Care (LTC) Plan addresses client barriers to HIV medical care discussed during the LTC Assessment. The plan is a place to prioritize and document self-identified needs and clearly outlines tasks that the Linkage Case Manager and client agree to accomplish within a specified period of time, in order to meet the goal of linkage to HIV care. Because the LTC Plan clearly outlines tasks and documents progress, the plan keeps the client moving toward the goal of accessing HIV medical care and may be used as a motivating tool that illustrates what the client has accomplished and what they are currently working toward.



The LTC Plan should be developed in conjunction with the assessment during the first session. The plan should be revisited during each subsequent session with the client and updated when tasks or objectives are accomplished.

It is important to recognize that a client can have many competing needs, priorities, concerns or life issues for which they may need long-term support. It may be unlikely that a Linkage Case Manager can resolve them all in the limited amount of time that they have to work with the client. The provider must **prioritize and distill the underlying and immediate challenges and barriers to HIV care linkage and work with the client to successfully address those challenges**. Care coordination services at the medical home site once client is linked to HIV care can then continue working with the client to address remaining concerns and will work with the client to ensure ongoing engagement in care and medication adherence.

As with the assessment, it is important to continue providing services from a strength-based perspective by infusing the LTC Plan process with the Strengths-Based Exploratory Process, focusing on the last two highlighted columns (“Other Resources” and “Plans and Next Steps”).

Table 6: A Strengths-Based Exploratory Process – LTC Plan

Stories and Challenges	Picture of the Future	Strengths and Exceptions	Other Resources	Plans and Next Steps
Ask questions that invite people to share their stories and enable them to clarify the challenges.	Ask questions that help people explore their aspirations, dreams, interests, and goals.	Ask people that help people explore their strengths and the exception to the challenge.	Ask questions that help the person identify resources that might help them reach their goals.	Ask questions that enable people to specify concrete steps towards their goals.
What’s happening? How do you feel about this? How long has this been a concern for you?	What do you want to be happening instead? What will it look like when this challenge is addressed?	What strengths do you have that might be helpful? What do you do well?	Who else might be able to help? What other skills and resources might be helpful?	What steps can be taken given your picture of the future, strengths and resources? Who will do what? When? How? By when?
How is it affecting you and others?		What is happening when the challenge is not present?		

As Linkage Case Managers, follow the steps below when developing a LTC Plan with a client. The process primarily includes objective setting, problem solving and monitoring progress, which are all necessary skills to promote self-management (Swedeman, Ingram, & Rotheram-Borus, 2009).

- 1) **Summarize client's needs identified during the assessment** following its completion. Solicit feedback from the client to ensure clarity.
- 2) **Prioritize with the client the issues** that hinder his or her linkage to HIV care. Ask the client, ***"Of all the things discussed, what can assist you in linking to HIV care?"*** This helps to frame the conversation as solutions-oriented and directs the client to focus on the most salient issues related to HIV care. Reframe barriers as opportunities for problem-solving.
- 3) **Frame the purpose and reason for the LTC Plan.** Let the client know that the plan is designed to support clients in linking to HIV care by addressing their self-identified barriers to HIV care through the adaptation and enhancement of existing client strengths, skills, and resources.
- 4) **As you discuss the client's barriers and develop the plan, assess the client's readiness to access HIV care** using the Stages of Change model. Is the client in:
 - **Precontemplation:** Client has no intention of entering HIV care;
 - **Contemplation:** Client is thinking about entering or re-entering HIV care but remains ambivalent; or
 - **Ready for Action:** Client is ready and willing to access HIV care in the immediate future?
- 5) **Assist the client in developing stage-appropriate objectives** based on your assessment of their readiness to enter HIV care. Follow the guidelines for developing [S.M.A.R.T. objectives](#) below. (If viewing the guidelines electronically, you may click on hyperlink and it will take you directly to the corresponding section).
 - a. **If client is "ready for action", develop objectives to link client to HIV care immediately.**
 - b. **If client is in precontemplation or contemplation, motivate client to address the challenges to accessing HIV care.** Work with the client to establish concrete objectives that:
 - i. Relate to the identified barriers to HIV care; and
 - ii. Support access and linkage to HIV medical services
- 6) **Divide each objective into manageable tasks needed to achieve the objective.** For example, an objective to receive HIV healthcare coverage may involve several tasks to accomplish, including identifying insurance plans for which they qualify; collecting all of the documentation necessary to apply; and completing health insurance applications.

At this time, it may be necessary to:

- a. inventory needed skills to accomplish the goal;
- b. assess the client's current skill level; and
- c. determine how to enhance needed skills to complete the necessary tasks.

- 7) **Identify who must complete each task or step.** Ensure that your collaborative relationship fairly balances the responsibilities outlined. Avoid working harder than the client. Ultimately, they are responsible for their own welfare.
- 8) **Discuss any barriers or challenges to completing each task.** Strategize ways to overcome these concerns by adapting or enhancing existing client strengths, skills and resources. Encourage client to “look back” at times in the past they were able to solve a problem and how they could apply those some strategies to the current tasks at hand.
- 9) **Identify a date by when each task and objective must be completed.** Allow realistic timelines. Remember that the time you have to work with the client is limited to five (5) sessions over three (3) months or less.
- 10) **Summarize next steps** for you and the client. Highlight the tasks that must take place in the immediate future and/or before you meet again.
- 11) **Establish when you will check in with the client.** Negotiate and schedule a day/time to meet with the client:
 - a. For their next LCM session if they are not ready to link to HIV care yet; or
 - b. To accompany them to their next medical appointment if they are ready to link to HIV care immediately.
- 12) **Following the session with the client:**
 - a. **Revisit the plan as needed during future contact.**
 - b. **Maintain appropriate documentation in the client record.** The LTC Plan should include:
 - i. Name, date and signature of client and Linkage Case Manager on the plan. Subsequent revisions may be dated and initialed.
 - ii. Immediate barriers to HIV care.
 - iii. Objectives that address the barriers to HIV care, including:
 1. What the client and Linkage Case Manager will do to accomplish the objective (tasks);
 2. Timeframe by when tasks are expected to be met; and
 3. Outcome of each objective, including if it was met, revised, or determined as unattainable.

See [Appendix E](#) for an example of a LTC Plan.

S.M.A.R.T. Objectives

Follow the guidelines for developing **S.M.A.R.T.** objectives when developing the LTC Plan with clients:

Specific: Clearly define the objective, including the what, why, and who. What will be done? Why will it be done? Who will do it?

Examples:

*Victor (**who**) will call the Midcity HIV Clinic (**what**), so he can schedule his first HIV medical appointment (**why**).*

*Sarah (**who**) will arrange child care for her daughter (**what**), so she can attend her HIV medical appointment (**why**).*

Measurable: Set criteria to measure progress towards the objective. How will you know if the objective is reached or accomplished? For example, an objective to schedule an HIV medical appointment may involve several tasks to accomplish, including identifying an HIV clinic to attend, obtaining the clinic's contact information, calling the clinic to schedule an appointment, and arranging a date to attend the appointment, which may require additional tasks such as setting up childcare, arranging transportation, getting time off from work, etc.

Achievable/Attainable: Ensure the objective can be reached with the proper tools. Developing different attitudes, abilities and skills may be necessary. Keep in mind that a good objective should challenge and stretch someone outside of their comfort zone. An objective that is too easy will not allow a person to grow, while an objective that is unrealistic will only discourage, frustrate and foster fatalism. Some objectives may be more complex than others due to higher acuity or client readiness to change and require multiple tasks to achieve.

Relevant: Ensure the objective aligns with the goal of Linkage Case Management—linking clients to HIV medical care and reducing HIV/STD risk behavior. It must also be an objective the person is willing and able to prioritize and work towards.

Timely: Develop a realistic timeframe or target date to achieve the objective. Too short and the person risks automatic failure. Too long and you invite procrastination.

Linkage to HIV Medical Services

The main goal of LCM is to facilitate access to and engagement in HIV care by linking clients to an HIV medical home or other system of HIV medical care. Linkage to HIV medical care is defined as one (1) face-to-face medical visit with an HIV medical provider, such as the medical doctor, nurse practitioner or physician assistant, within ninety (90) days of the LCM intake and assessment. For some clients, this may happen within the first or second session. Other clients may take longer to engage. In a similar LCM model, clients, on average, had 2.6 sessions during the intervention (Gardner, 2005).

As Linkage Case Managers, follow the steps below when linking clients to their chosen medical care site once the client indicates readiness to link to HIV care. **This can happen during any intervention session and at any time within the ninety (90)-day period:**

- 1) Reinforce the client's decision to link to HIV medical services.** Validate their reasons for seeking HIV care;
- 2) Discuss with the client a few HIV clinic options.** Review with them the characteristics of each clinic, including the clinic culture, typical clientele served, their registration process and other relevant factors that may influence their decisions (e.g., location, accessibility to public transportation, services co-located at clinic site). Avoid allowing your own biases direct the decision-making process; ensure the decision is the best fit for their needs.

If client has been engaged in HIV care before, discuss with client their likes and dislikes about their past HIV clinic experiences. Assure the client that they are welcome to return to their previous clinic or to choose a different one that appears to be a better fit.

- 3) **Allow the client to choose the HIV clinic that best suits their needs.**
- 4) **Review with client what to expect during the first couple of medical visits.** Discuss what documents the client needs to have/bring to the first appointment in order to access services, the intake process, when they will be able to see the HIV medical provider (this can vary among the different medical sites) and the possibility of wait times.
- 5) **Assist client in scheduling an HIV medical appointment.** Having the client make the appointment during the session provides 1) an opportunity for them to practice this task; and 2) confirmation that an appointment was made. Ensure that the client confirms with the receptionist what information or other documentation they must bring to their first appointment and if/when the client will see an HIV medical provider. This will help clarify the clinic process and manage their expectations.
- 6) **Trouble-shoot with client any potential barriers to following through with appointment(s).** This might mean transportation concerns, potential scheduling conflicts, ability to remember, etc.
 - a. Because transportation is identified as a common barrier to HIV healthcare access, spend some time assisting the client in navigating travel, whether by personal car or public transit (Syed, 2013); (Valverde, 2006). Use what you know about the clinic and its location to facilitate this process. In some cases, it might be helpful to ride public transit (bus or metro) with the client to their initial appointment to help them navigate the system and build their confidence in managing the trip alone in the future.
- 7) **Summarize what the client must do to make the linkage a success.** Review the day/time of their medical appointment(s), where they need to go and how they will get there, what they need to bring, etc.
- 8) **Accompany newly diagnosed client to their first medical visit with the HIV medical provider as needed,** in order to provide support and ensure linkage.
- 9) If you did not accompany client to their first medical visit, call the HIV clinic and client to **confirm the client attended their medical appointment.**
- 10) **Elicit feedback from the client about their medical visit.** What went well? What could be better next time?
- 11) If clients require longer term case management support to address on-going issues that may impair retention in HIV care or HIV medication adherence, **refer client to care coordination services at the HIV clinic.** Care coordination is defined as a provider or team of providers who actively coordinate(s) the psychosocial and socioeconomic needs of the client with the goal of optimal engagement in HIV medical care. Care coordination may be provided by a registered nurse (RN), social worker or other counseling professional (e.g., marriage and family therapist), and/or para-professional staff with experience linking clients to needed psychosocial and other supportive services.

The following steps are best practices in terms of facilitating a successful referral to care coordination:

- a. With the client, **frame the importance of ongoing engagement in HIV care.** Let them know that entry is the first step to a long-term relationship with HIV care and emphasize the need to continuing seeing an HIV medical provider throughout their life for optimal health.

- b. **Introduce the concept of care coordination.** Key points to highlight with client:
 - i. Care coordination is designed to assist clients in managing their HIV care effectively.
 - ii. Care coordination staff can continue to work with the client to support newly adapted behaviors and increase self-efficacy in maintaining optimal engagement in HIV care. This is a good opportunity to continue planting the seed of graduated disengagement from LCM.
 - iii. Frequent contact with the care coordination staff may be necessary at first but the level of intensity will reduce once the client is back on track with their HIV care.
- c. **Assist the client in identifying the care coordination staff** at the client's chosen HIV clinic.
- d. **Facilitate a "meet-and-greet" between the client and care coordination staff** in-person or by phone. This allows the client to become familiar with the care coordination staff at their HIV clinic.

12) **Document linkage to HIV care** and any follow up in your progress notes and file in the client's chart. Include the date, time spent providing assistance with the HIV care linkage.

13) **Track time spent ensuring linkage to HIV medical services in Casewatch.** Time spent documenting linkage and follow up is considered part of time spent ensuring linkage. Enter time under "Monitoring Client Progress" in the Casewatch "Client Service Encounter" screen for the LCM module.

Time spent ensuring linkage to HIV care is tracked and included under the "Number of Service Hours: Monitoring" column in the monthly report.

Behavioral Interventions

The following behavioral interventions, including HIV education, risk reduction counseling and disclosure assistance, may be delivered as needed to promote HIV care linkage but are in no way required as part of LCM. LCM's one and only goal is to link clients to HIV medical services. This means if clients are linked prior to the delivery of these activities, the program's goal has been achieved.

However, it may be necessary to deliver behavioral interventions to address issues identified in the Assessment that prevent linkage to HIV care for some clients who are unable to immediately link to HIV care due to more complex barriers, such as denial of HIV status, HIV stigma (internal or external), mental disorders, and substance use. While the likelihood of completely resolving some of these issues within the ninety (90)-day period is small, the goal is to promote a change in the client's thinking and/or behavior that will directly lead to HIV care linkage as soon as possible.

As Linkage Case Managers, follow the steps below when delivering behavioral interventions:

- 1) **Introduce the issue in the context of linkage to HIV care.** Articulate the connection between the concern and accessing HIV care.
- 2) **Introduce the issue in the context of linkage to HIV care.** Articulate the connection between the concern and accessing HIV care.

- 3) Use the information collected in the Assessment and **explore the issue further with the client.** Use open-ended questions and other MI techniques to elicit a greater understanding of any context in which current behavior(s) or thoughts occur and how they affect linkage to HIV care. Recognize that some issues will be more sensitive than others. Watch and prepare for defensiveness or other resistance. Explore resistance when necessary.
- 4) **Provide feedback.** Highlight how aspects of the client’s behavior(s) or thoughts affect linkage to HIV care. Use reflective listening skills and other MI techniques to explore solutions and possible ambivalence; listen for DANCER—desire, ability, need, commitment and reasons for behavior change. Provide affirmations when appropriate. Be aware of cultural, language, and literacy issues; remain nonjudgmental.
- 5) Talk about change and set goals to **move clients along the behavior change continuum** toward linkage to HIV care. Explore values and attitudes that support linkage. Discuss the possibilities of change, and reframe behavior or thoughts that prevent linkage.
- 6) **Develop a plan of action when the client is ready to act.** Always be mindful of the client’s readiness to change and frame the discussion using stage-appropriate cues. Suggest a course of action and then negotiate with the client to determine exactly what they are willing to do.
- 7) **Avoid “giving advice.”** This often leads to defensive behavior. Elicit from the client their own problem-solving skills and let them take the lead in developing next steps whenever possible.
- 8) **Summarize the intervention.** Highlight any progress the client has made during the session and to what steps they have agreed, in order to move forward. Close the conversation with the goal of leaving the client feeling successful and confident in their ability to follow through with next steps.
- 9) **Following the intervention with the client:**
 - a. **Follow up with the client** to confirm whether they were able to act on their plan and how well their plan went. Positively reinforce successes; constructively explore solutions to any setbacks; and provide any needed emotional support and positive affirmations.
 - b. **Document the content of the intervention** and any follow up in your progress notes and file in the client’s chart. Include the date, time spent providing behavioral interventions and what was discussed, including any skills building activities delivered to the client during the intervention.
 - c. **Track time spent providing behavioral interventions in Casewatch.** Time spent documenting behavioral interventions and follow up is considered part of time spent conducting behavioral interventions. This means if a provider spent 45 minutes providing behavioral interventions and 15 minutes documenting the session, they may enter one hour under “Behavioral Intervention Session” in the Casewatch “Client Service Encounter” screen for the LCM module.

Time spent conducting behavioral intervention sessions is tracked and included under the “Number of Service Hours: Interventions” column in the monthly report.

HIV Education

Information alone rarely changes behavior but is the foundation on which informed decisions can be made. Without a fundamental understanding of HIV transmission and treatment, clients may be unable to assess accurately the importance of primary HIV healthcare and treatment, and to prioritize HIV medical services for their health and overall well-being. HIV education and skills needed to prevent further HIV transmission and acquisition of additional STDs also work in concert to promote HIV/STD risk reduction (see [Risk Reduction Counseling](#) for more information about harm reduction activities). Linkage Case Managers are responsible for providing HIV education to clients with limited knowledge of HIV infection and transmission.

As a Linkage Case Manager, follow the steps below when delivering HIV education to a client when opportunities occur during the course of delivering brief intervention sessions. For example, address HIV education topics when a client expresses misinformation about HIV or asks questions related to HIV education. If an opportunity doesn't arise naturally during the course of conversation with the client, make an effort to address it separately if you deem HIV education will further motivate them to link to HIV care.

- 1) **Ask the client to review what they already know about HIV.** They may have a lot of knowledge about HIV, particularly clients who are not new to HIV care or who had an informative HIV testing disclosure session. At the same time, do not assume that clients with an HIV care history know a lot of about HIV.
- 2) **Correct any misinformation and reinforce accurate information** shared by the client.
- 3) **Ensure the following topics are addressed:**
 - **What HIV is;**
 - **How HIV is transmitted;**
 - **The difference between HIV and AIDS;**
 - **What HIV viral load and CD4 count measure and how it impacts their health;**
 - **Purpose of HIV medical care and medication; and**
 - **What to expect once they engage in HIV care.**

Please note these conversations are limited in scope and are **not** intended to provide specific information about treatment options or antiretroviral drug regimens.

Some tips when providing HIV education are below:

- Deliver all information as simply and straightforward as possible. Use simple, non-technical words (e.g., minimize acronyms), and keep your statements as brief as possible.
- Ensure written material is easy to read. Choose materials with clean formatting and simple, plain language with a 7th grade literacy level or (preferably) less. For resources on plain language, go to:

Plain Language Action and Information Network (PLAIN)
www.plainlanguage.gov

Center for Plain Language
<http://centerforplainlanguage.org>

4) **Confirm understanding from the client.** The client should be able to articulate the following basic information:

- a. HIV is the virus that infects a person. The virus affects a person by damaging their immune system, making them more susceptible to other infections. AIDS is a diagnosis given by a medical provider when a person living with HIV has a weakened immune system that they contract an opportunistic infection or their CD4 count drops below 200 ml/uL.
- b. HIV is transmitted through blood, semen, vaginal fluid, pre-cum and breast milk.

HIV can be transmitted during sexual activity (primarily vaginal and anal sex without a condom) and sharing needles *for any reason (recreational drugs, vitamins, hormones, etc.)* with a person who has HIV. Infants can get HIV by breast-feeding from a woman with HIV.

It is **not** transmitted through tears, sweat, saliva, urine or feces.

- c. HIV viral load is a measurement of the amount of virus in a person's blood. The higher the viral load, the more damage the virus can do to the person's immune system and will usually cause the number of T-cells (CD-4) to drop. The goal of HIV treatment is to lower the viral load. The best viral load test result is "undetectable."

An "undetectable" viral load means a person still has HIV but the amount of virus in their blood is so small that current tests cannot detect it. A consistent undetectable viral load will usually result in an increase in the number of T-cells (CD-4). Studies show that people with "undetectable" viral loads are also less likely to pass the HIV virus on to others.

- d. CD4 count is a measurement of how healthy a person's immune system is. The lower the CD4 count, the more likely a person can become or feel sick. The goal of HIV treatment is to stabilize or increase a person's CD4 count.
- e. HIV medication, often called anti-retroviral therapy (ART), is life-long treatment that helps people with HIV to live longer, healthier lives by decreasing their viral load and improving their immune system. ART is recommended for everyone living with HIV.
- f. HIV is a chronic illness, and HIV medical care and medication is a life-long commitment. Successful engagement in HIV care means going to see an HIV doctor regularly and taking medications as prescribed. It is also important to ask the doctor questions when needed and to be honest with the doctor about what is going on with one's health and related behaviors.

Providing a client with an HIV fact sheet or a newsletter with HIV information is a great complement to, but should not count on its own, as an HIV education session.

5) **Following the intervention with the client:**

- a. **Document the content of the HIV education intervention in your progress notes** and file in the client's chart. Include the date, time spent providing HIV education, and what was discussed.
- b. **Track time spent providing HIV education in Casewatch.** Time spent documenting HIV education is considered part of time spent conducting HIV education. This means if a provider spent 30 minutes providing HIV education and 10 minutes documenting the intervention, they may enter 40 minutes under "HIV Education Sessions" in the Casewatch "Client Service Encounter" screen for the LCM module.

If HIV information was shared while conducting another brief intervention activity, such as the Linkage to Care Assessment and Linkage to Care Plan, track the time spent providing HIV education under “HIV Education Sessions” and the other time spent conducting the other activity(ies) under the appropriate task(s) in the “Client Service Encounter” screen. This means if a provider spent 15 minutes providing HIV Education during an hour long assessment session, count 15 minutes of that encounter under “HIV Education Sessions” and 45 minutes under “Baseline Assessment” in the “Client Service Encounter” screen.

Time spent conducting HIV education is tracked and included under the “Number of Service Hours: Interventions” column in the monthly report.

Risk Reduction Counseling

Clients remain at risk for HIV/STD re-infection and infection, as well as transmitting the virus to others. Approximately one-third of HIV-positive clients continue to engage in risky sexual and drug-use behaviors following their HIV diagnosis (McGowan, Shaw, Ganea, & et al, 2004); (Metsch, Pereyra, Messinger, & et al, 2008); (Fisher, Fisher, Cornman, & et al, 2006); (Kalichman, Cherry, White, & et al, 2011). Addressing unprotected sex is a high priority when working with HIV positive individuals.

Risk reduction counseling builds on HIV/STD knowledge to motivate and empower clients with strategies to reduce their risk of HIV/STD transmission and acquisition. It goes beyond mere delivery of information; it is a dynamic interaction between the Linkage Case Manager and client designed to motivate and support clients in changing behaviors.

As Linkage Case Managers, it is your role to use motivational interviewing and other counseling techniques during brief intervention sessions to:

- 1) **Identify and discuss the client’s risk behavior(s) and the context** surrounding their risk behavior (e.g., where, when, with whom, triggers or patterns).
- 2) **Motivate client to prioritize risk reduction;**
- 3) **Build behavioral skills** that are consistent with the client’s readiness to change. See [“Harm Reduction Activities”](#) for more information.
- 4) **Develop mutually agreed upon and achievable risk-reduction strategies** that enable the client to initiate and sustain behaviors that reduce his or her risk of contracting or transmitting HIV/STDs through sex and substance-using behaviors. This may mean strategies to reduce number of sex partners with whom (or times when) condoms are not used or strategies to reduce number of partners with whom (or times when) needles are shared.
- 5) **Emphasize HIV care and treatment as a risk reduction strategy.** Let the client know that people with “undetectable” viral loads are also less likely to pass the HIV virus to others.
- 6) **Monitor progress.** Positively reinforce successes. Constructively explore solutions to any setbacks.
- 7) If a client expresses that they consistently practice harm reduction, **explore their current strategies and offer positive reinforcement.**
- 8) If a client expresses that they do not currently engage in sexual or needle-sharing activities, **explore with them:**

- a. **Strategies that they have used in the past; and/or**
- b. **Possible risk reduction strategies that they might use if/when the situation were to arise in the future.**

9) **Summarize the intervention.** Emphasize any progress the client has made and to what steps they have agreed, in order to move forward. Close the session with the goal of leaving the client feeling successful and confident in their ability to follow through with next steps.

10) **Following the intervention with the client:**

- a. **Document the content of the risk reduction counseling session** and any follow up in your progress notes, and file in the client's chart. Include the date, time spent providing risk reduction counseling and what was discussed, including any skills building activities delivered to the client during the intervention.
- b. **Track time spent providing risk reduction counseling in Casewatch.** Time spent documenting risk reduction counseling is considered part of time spent conducting risk reduction counseling. This means if a provider spent 30 minutes providing risk reduction counseling and 10 minutes documenting the intervention, they may enter 40 minutes under "Risk Reduction Counseling Sessions" in the Casewatch "Client Service Encounter" screen for the LCM module.

If risk reduction counseling was done while conducting another brief intervention activity, such as the Linkage to Care Assessment and Linkage to Care Plan, track the time spent providing risk reduction counseling under "Risk Reduction Counseling Sessions" and the other time spent conducting the other activity(ies) under the appropriate task(s) in the "Client Service Encounter" screen. This means if a provider spent 15 minutes providing risk reduction counseling during an hour long assessment session, count 15 minutes of that encounter under "Risk Reduction Counseling Sessions" and 45 minutes under "Baseline Assessment" in the "Client Service Encounter" screen.

Time spent conducting risk reduction counseling sessions is tracked and included under the "Number of Service Hours: Interventions" column in the monthly report.

Harm Reduction Activities

As part of risk reduction counseling, the Linkage Case Manager will need to address sexual and substance-using behaviors by providing accurate health information and education to clients regarding HIV prevention, transmission and risk behavior management. The harm reduction skills clients may need include the following:

- Exploration of values, beliefs and reasons that promote risk reduction behaviors
- Skills necessary to reduce risk (e.g., engaging in lower risk sexual behaviors, using male or Reality (commonly referred to as "female") condoms⁶, cleaning needles and works, obtaining new needles and works)
- Negotiation strategies for safer sex (e.g. discussing condom use with partners)

It is important to remember that risk reduction related to HIV transmission involving people living with HIV primarily means techniques that reduce the likelihood of transmitting the virus to their

⁶ "Reality Female" condoms can be used by women during vaginal intercourse, as well as by men and women during anal sex. Because of this, it can be useful to introduce this type of condom in a gender-neutral way by simply referring to them as "Reality" condoms.

partner(s) versus techniques to protect themselves against HIV infection. For example, this may entail advising clients to act as the receptive partner versus insertive partner when having sex with an HIV-negative person. However, this would make the client more vulnerable to STD acquisition. For clients with discordant sexual partners, information and resources about pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to share with their partner(s) might be helpful.

Disclosure Assistance

The topic of clients disclosing their HIV status is typically framed with regard to needle sharing and sex partners as a strategy to promote risk reduction. However, it is equally important to encourage disclosure to family and friends to enhance social support and increase the number of people in the client's life that can support their efforts to link and adhere to HIV care. Studies show individuals who are able to disclose their HIV status typically benefit through greater acceptance of and comfort with HIV status; a reduction in stress related to disclosure issues; and increased social support from partners, family and friends—all of which can improve readiness to engage in HIV care and promote HIV treatment plan adherence. Clients who disclose their HIV status to friends and family are also more likely to be retained in HIV care (Wohl, Galvan, Myers, & et al, 2011).

As Linkage Case Managers, follow the steps below when discussing HIV disclosure with a client during brief intervention sessions if it is determined that HIV disclosure is critical to moving a client forward in linking to HIV care. For example, a client may feel the need to disclose their status to friends or family members that they live with; will rely on for transportation to, or childcare during, HIV medical appointment(s); and/or require emotional support from prior to linking to HIV care.

- 1) **Explore the client's experiences and feelings** around sharing their status with a friend or family and how that might assist them in linking to HIV care.
- 2) **Motivate client to disclose their HIV status** and highlight the potential benefits of sharing their status with friends and family.
- 3) Problem-solve how to overcome perceived barriers to disclosure with client.
- 4) If the client chooses to share their HIV status with (a) friend(s) or family member(s), **support the client in developing a plan for disclosure**. Have them think about the when, where, and how (what words will they say) of disclosure and assist them in thinking through "what-ifs", including how the person(s) will react, and who they might tell about the client's status.
- 5) **Summarize the intervention**. Emphasize any progress the client has made and to what steps they have agreed, in order to move forward. Close the discussion with the goal of leaving the client feeling successful and confident in their ability to follow through with next steps.
- 6) **Following the intervention with the client:**
 - a. **Follow up with the client** to confirm whether they were able to act on their plan and how well their plan went. Positively reinforce successes; constructively explore solutions to any setbacks; and provide any needed emotional support and positive affirmations.
 - b. **Document the content of the intervention** and any follow up in your progress notes and file in the client's chart. Include the date, time spent providing disclosure assistance and what was discussed, including any skills building activities delivered to the client during the intervention.

- c. **Track time spent providing disclosure assistance in Casewatch.** Time spent documenting disclosure assistance and follow up is considered part of time spent conducting disclosure assistance. This means if a provider spent 20 minutes providing disclosure assistance and 10 minutes documenting the intervention, they may enter 30 minutes under “Disclosure Assistance Sessions” in the Casewatch “Client Service Encounter” screen for the LCM module.

If the disclosure assistance was done while conducting another brief intervention activity, such as the Assessment, Linkage to Care Plan or risk reduction counseling, track the time spent providing partner services under “Disclosure Assistance Sessions” and the other time spent conducting the other activity(ies) under the appropriate task(s) in the “Client Service Encounter” screen. This means if a provider spent 20 minutes providing disclosure assistance during an hour long risk reduction counseling session, count 20 minutes of that encounter under “Disclosure Assistance Sessions” and 40 minutes under “Risk Reduction Counseling Sessions” in the “Client Service Encounter” screen.

Time spent conducting disclosure assistance sessions is tracked and included under the “Number of Service Hours: Interventions” column in the monthly report.

Monitoring

Monitoring provides ongoing support by maintaining contact with the client to ensure they follow through with the tasks agreed upon in the LTC Plan and monitor their readiness to link to HIV care. Ongoing contact with the client during brief intervention sessions is important, in order to:

- Achieve objectives;
- Evaluate whether services are consistent with the needs of the client;
- Determine if any changes to objectives are necessary to support linkage to HIV care goal; and
- Assess whether client is ready to link to HIV care.

Additionally, these activities ensure that other needed services are obtained through linked referrals in a timely, coordinated manner. This means following up with clients and/or service providers to confirm linkages.

Monitoring activities are primarily conducted during the brief intervention sessions with the client, or by phone with the client and other providers when facilitating linkage to needed services.

As Linkage Case Managers, conduct the following when performing monitoring activities during brief intervention sessions:

- 1) **Assess clients’ readiness to link to HIV care;**
- 2) **Increase clients’ motivation to access HIV care.** This includes assessing and fostering their desire, ability, need, commitment, and reasons for linking to HIV care.
- 3) **Increase clients’ motivation to prevent HIV/STD transmission and acquisition.** This includes assessing and fostering their desire, ability, need, commitment, and reasons for risk reduction activities.
- 4) **Ensure LTC Plan remains relevant to clients’ immediate needs related to linkage to HIV care;**
- 5) **Assist clients in resolving barriers to completing LTC Plan objectives,** including accessing needed services;

- 6) **Link clients to HIV care whenever the client indicates they are ready.** This may happen at any time during the ninety (90)-day intervention.
- 7) **Following the session with the client** (or if the client missed the session):
- a. **Follow-up with clients who have missed a LTC brief intervention session** within twenty-four (24) hours of broken appointment. If follow-up activities are not appropriate or cannot be conducted within the twenty-four (24) hour time period, Document reason(s) follow-up was delayed.
 - b. **Maintain appropriate documentation of monitoring activities in progress notes** and file in the client's record. Documentation should include:
 - i. Name, date and signature of Linkage Case Manager;
 - ii. Type of contact with or on behalf of client;
 - iii. Description of what occurred during contact, including:
 1. Changes in the client's condition or circumstances;
 2. Progress made towards achieving the objectives identified in the LTC Plan and client's progress toward accessing HIV medical care; and
 3. Barriers identified in completing LTC Plan and actions taken to resolve these barriers;
 4. Current status and results of referrals, linkages and interventions, including any barriers and actions taken to resolve those barriers.
 - c. **Track time spent monitoring in Casewatch.** Time spent documenting monitoring activities is considered part of time spent monitoring. Enter time under "Monitoring Client Progress" in the Casewatch "Client Service Encounter" screen for the LCM module.
- Time spent conducting monitoring activities is tracked and included under the "Number of Service Hours: Monitoring" column in the monthly report.

Intervention Extension

Intervention extension allows Linkage Case Managers to provide additional support for up to 30 days to clients not yet ready to link to HIV care following the completion of the 5 face-to-face sessions over the initial ninety (90) day-period. The extension of services allows the Linkage Case Managers to work more intensively with the client to promote readiness and self-efficacy to access and/or link to HIV care. Services delivered during this period are limited to monitoring client's progress on LTC Plan objectives, brief interventions to promote HIV care and risk reduction behaviors, and referral linkage. **All extensions require prior approval from DHSP.**

As a Linkage Case Manager, you can request a LCM intervention extension by following the steps below:

- 1) **Complete the DHSP LCM Intervention Extension Request Form.** See [Appendix F](#) for a copy of the Intervention Extension Request Form. As indicated on the form:
 - a. Submit a copy of the original LTC plan which indicates the LTC plan objectives and the disposition of each objective;
 - b. Explain how the additional time with the client will likely result in linkage to HIV care by the end of the 30-day extension, including any proposed changes in strategies;

- c. Include the program supervisor’s recommendations; and
 - d. The program supervisor must sign the request in approval.
- 2) **Submit request at least two (2) weeks prior to the end of the ninety (90)-day intervention period.**
- a. **Submit completed request using a secure fax line to (213) 738-6566 or encrypted email to CSDinbox@ph.lacounty.gov and copy your DHSP Program Manager** (as indicated on the request form).
 - b. If sending by email, type “[**your agency name**] - **LCM Extension Request**” in the budget line.
 - c. If sending by email, **send e-mail as a “high importance” status email.**

DHSP will respond to the request within **seventy-two (72) hours.**

GRADUATED DISENGAGEMENT

Graduated disengagement is the process of transitioning a client from LCM services. It begins during the very first meeting with the client and is reinforced throughout the intervention until the client is disengaged. This process includes formally notifying clients of pending transition and completing a graduated disengagement summary. Disengagement may occur for the following reasons:

- Client linkage to primary HIV care,
- Relocation outside of the County of Los Angeles,
- Transfer to another service agency,
- Client incarceration,
- Voluntary termination of services by client,
- Unacceptable client behavior defined as threatening and/or abusive behavior directed toward the clinic staff or other clinic clients, or
- Client death.

Linkage Case Managers should follow the steps below during the process of client graduated disengagement:

- 1) **Introduce the concept of graduated disengagement when you first begin to work with the client.** Inform them for the very beginning that LCM is a time-limited intervention designed to link them to HIV care and the supportive care coordination provider(s) at the clinic.
- 2) When a client is ready to link to HIV care, **let them know the process of linkage and re-emphasize your limited role once the client links to HIV care.** Remind them that your main focus was to support them in linkage to HIV care. Their successful linkage to HIV care means they have demonstrated greater self-efficacy in managing their health and no longer require your support. Provider(s) at the clinic will continue to work with them to ensure ongoing engagement in care.
- 3) If clients require longer term case management support to address on-going issues that may impair retention in HIV care or HIV medication adherence, **refer client to care coordination services at the HIV clinic.** Clarify that any pending LTC Plan objectives or unresolved concerns should be

discussed with the care coordination staff. Assist them in developing a list of concerns to address with the care coordination provider(s).

- 4) For clients who are not ready to link to HIV care by the end of the intervention, highlight the work that you and the client have done during your time together. **Let them know that you are available to link them to HIV care once they are ready to link to care** and that you plan to follow up in **ninety (90) days** to see how they are doing if they do not contact you before then.
- 5) **Notify the client that you plan to contact them** in 90 days to:
 - a. Ensure that they remain linked to HIV care; or
 - b. Check whether they are ready to seek HIV care if they are not yet linked.
- 6) **Confirm client contact information for the follow up** in ninety (90) days. It is strongly recommended to collect a few different methods of contacting them. This may include multiple phone numbers or other means of contact in the event that their phone number(s) change or become disconnected, such as e-mail or social media outlets (e.g., Facebook, etc.). Assure them that the follow up will not take place over e-mail or social media for confidentiality reasons. These methods would only be used to schedule a phone or in-person conversation.
- 7) **Document disengagement** in signed progress notes and file in the client's record. Documentation should include, but not be limited to, the following:
 - a. Summary of client's status at time of transition;
 - b. The reason for transition, as well as;
 - i. Location of their new Linkage Case Manager or care coordination provider(s) if client transitioned to another service provider or was linked to HIV care, respectively;
 - ii. Where the client moved If client relocated;
 - iii. Reasons why the client chose to terminate services. ; or
 - iv. Description of unacceptable behavior if client was discharged due to actions.
 - c. Status of primary health care and support services utilization;
 - d. Transition plan, if appropriate.

The clinical supervisor must review, approve, sign and date client's graduated disengagement summaries. See [Appendix G](#) for a sample of the Graduated Disengagement Summary Form.

FOLLOW UP

Linkage Case Managers shall contact each client ninety (90) days following graduated disengagement in person. The follow up is to ensure clients linked to HIV medical homes remain engaged in HIV care, or to provide an additional opportunity to link clients to HIV care for those who were not successfully linked to HIV medical services during the initial intervention. The ninety (90) day follow up shall be conducted by phone.

Linkage Case Managers should follow the steps below during the process of follow up:

- 1) For clients who were linked to HIV care during the initial LCM intervention:
 - a. **Contact client to confirm whether client remained engaged in HIV care.** “Contact” is defined as speaking with the client. This may require several attempts to reach out before contact is made. Just leaving a message for the client does not suffice as contact.
 - b. **Solicit feedback on the client’s recent HIV care experience.**
 - c. **Confirm with HIV clinic that the client remains linked to HIV care at their clinic.**
- 2) For clients who were not linked to HIV care during the initial LCM intervention:
 - a. **Contact client to see whether they linked to HIV care** within the last ninety (90) days. Contact is defined as speaking with the client. This may require several attempts to reach out before contact is made. Just leaving a message for the client does not suffice as contact.
 - i. For those who were linked:
 1. **Solicit feedback on the client’s recent HIV care experience.**
 2. **Confirm with their HIV clinic that the client is linked to HIV care.**
 - ii. For those not yet linked to HIV care, discuss barriers to linkage.
 1. **Assess client readiness to link to HIV care;**
 2. **Discuss client-identified barriers to HIV care;**
 3. **Attempt linkage if client indicates they are ready to link to HIV care;**
 4. **Document changes in the client’s condition or circumstances (if applicable); and**
 5. **Provide psychosocial service referrals, as needed; and**
 6. **Document outcome.**
- 3) Document follow up contact with client using the “Linkage Case Management Client Follow-Up Status” form (see [Appendix H](#)). File form in the client’s chart and enter data into Casewatch. Enter time spent conducting follow up under “Follow Up” in the Casewatch “Client Service Encounter” screen for the LCM module.

Time spent ensuring linkage to HIV care is tracked and included under the “Number of Service Hours: Monitoring” column in the monthly report.

ADMINISTRATIVE REQUIREMENTS

For agencies contracted by DHSP to deliver LCM services, there are additional administrative requirements outlined in the Non-medical Case Management services agreement. Review the administrative requirements that are in addition to the expectations for direct service delivery outlined above.

Start Up Activities

Prior to service delivery, it is important to conduct start up activities that will prepare the agency to implement LCM effectively. These activities are designed to ensure that necessary administrative, organizational and staffing procedures are developed and in place to ensure the program's smooth roll-out and success. Pre-implementation activities are as follows:

- Hire LCM staff. See contract exhibit for staffing requirements.
- Train LCM staff on service delivery expectations and ensure Linkage Case Managers complete opportunities for staff development.
- Enhance staff familiarity with HIV clinics and other community resources. This may require on-site visits and discussions with primary HIV care providers to understand procedures and required documentation needed for enrolling clients at their clinics.
- Evaluate how LCM services complement other agency programs. How will it be integrated into the portfolio of services already offered at the agency?
- Develop working relationships and formal MOUs with referring provider networks as part of the LCM outreach plan.
- Complete and submit an [outreach plan](#) for DHSP approval.
- Translate forms and/or develop strategies to accommodate clients who may not read English.⁷
- Increase agency's capacity to allow staff flexibility and mobility. This means establishing policies that address Linkage Case Managers' ability to meet with clients outside of the office setting and/or during non-traditional office hours.

Staff Development

Continuing education is critical for the professional growth of the Linkage Case Managers. All DHSP-funded Linkage Case Managers are required to participate in the following trainings in addition to ongoing agency staff training and support:

- **DHSP Data Management System Training:** The training is offered by Automated Case Management System (ACMS) and is designed to familiarize staff with data entry and tracking service delivery in the electronic data collection system called Casewatch. Call ACMS at (323) 460-7700 to schedule training once staff is authorized by the DHSP Program Manager to provide LCM services.
- **LCM Training:** This training acquaints staff with DHSP expectations for LCM service delivery and provides an opportunity to further develop staff capacity to delivery LCM services. It does not offer formal certification. **Linkage Case Managers are required to attend. LCM Supervisors are strongly encouraged to observe.**

⁷ Given that Spanish is the second most common language spoken in Los Angeles County, it is the expectation that agencies will translate client materials that must be understood and signed by clients. Other strategies may be developed to accommodate clients who are unable to read English.

Contact the DHSP Program Manager for upcoming training dates.

- Partner Services Training: Formerly known as Partner Counseling / Risk Reduction Services (PCRS), the training offers an overview of disclosure assistance services and enhances skills needed to support clients in making an informed decision about HIV disclosure. Training is available on how to support clients and deliver partner services.

For more information about training opportunities offered by DHSP, visit their website at www.ph.lacounty.gov/dhsp. A provider training calendar with dates and course descriptions is located at <http://www.ph.lacounty.gov/dhsp/trainings.htm>. The California STD/HIV Training Center also offers training courses on Partner Services. Visit their website at: <http://www.stdhivtraining.org>

- Sixteen (16) hours of continuing education per year. This may be in-person or web-based trainings. Staff development and enhancement activities should include, but not be limited to:
 - Motivational interviewing
 - Behavior change theory
 - Trauma-informed and other counseling methodologies
 - Risk behavior and prevention interventions;
 - Substance use and treatment;
 - Mental health and HIV/AIDS;
 - Family dynamics and developmental issues;
 - Cultural competency for marginalized populations (e.g., homeless or formerly incarcerated individuals)

Trainings intended to satisfy professional credentialing and requirements may be used to satisfy this requirement. Attendance at the LCM Training satisfies the 16 -hour continuing education requirement during the first year.

Documentation on file verifying staff attendance is required, such as a certificate of completion or letter verifying training completion. It should include:

- Participant's name
- Name of training
- Sponsoring agency
- Date of training
- Length of training (or number of continuing education credits)

Resources on in-person and/or online training opportunities for LCM staff may include, but are not limited to:

- HIV Drug and Alcohol Taskforce (<http://hivdatf.org>)
- Hollywood Homeless Youth Partnership (<http://hhyp.org>)
- The New York/New Jersey AIDS Education and Training Center (AETC) (www.nynjaetc.org)
- Pacific AIDS Education and Training Center (<http://paetc.org>)
- Shared Action (<http://www.sharedaction.org>)
- STD/HIV Prevention Training Center (www.stdhivtraining.org)

Monthly Reports

Agencies must enter, track and report client service delivery data to DHSP via monthly reports primarily using Casewatch, the current data collection system mandated by DHSP. The completed report must be submitted no later than thirty (30) days after the end of the reporting period (month). For example, April's report is due no later than May 30th. The report is only complete once it contains all report sections. The sections include:

- [Section I: Cover Summary Page](#)
- [Section II: Client Demographics](#)
- [Section III: Task Summary Report](#)
- [Section IV: Monthly Narrative](#)

Sections I through III are generated automatically by Casewatch when running the monthly report. Section IV is completed separately and submitted concurrently.

Section I: Cover Summary Page

Section I of the Casewatch report is the monthly report's cover summary page. The summary page lists:

- Agency contact information, i.e., name, address, telephone number, and fax number;
- Agency contract information, i.e., program name and service category, exhibit number, contract number, schedule number, and contract term;
- The report's reporting period;
- Who prepared the report; and
- Number of service hours by month and service planning area (SPA).

The summary page is also where the agency's designee signs and dates the report. The "**designee**" is a person authorized by the agency to sign documents on the agency's behalf, and must be on record with DHSP's Contracts Administration Division (CAD) as a designee. It is the designee's responsibility to ensure all information in the report is accurate; their signature is confirmation that they have verified that all information reported is correct.

Section II: Client Demographics

Section II of the Casewatch report tracks the demographics of clients served in the program during the reporting month and YTD. The demographic categories are pulled from Casewatch registration data and include:

- Gender
- Race/Ethnicity
- Language
- Age
- Income
- Housing/Living Arrangement
- Medical Insurance
- HIV/AIDS Status
- Primary Risk Factor(s)
- Incarceration History

Section III: Task Summary Report (Service Delivery Data)

Section III of the Casewatch report tracks service delivery and compiles the following:

- 1) Number of unduplicated clients served and service hours delivered during the reporting period and year-to-date (YTD) for:
 - a. Interventions activities
The following tasks are tracked as "Interventions" in the monthly report:
 - i. [Assessment](#)

- ii. [LTC Plan Development](#)
- iii. [HIV Education Sessions](#)
- iv. [Risk Reduction Counseling Sessions](#)
- v. [Disclosure Assistance Sessions](#)
- vi. [Behavioral Interventions](#)
- vii. [Follow Up](#)

b. [Monitoring activities](#)

Monitoring activities are tasks that ensure linkage to HIV care. These tasks are entered as “Monitoring Client Progress” activities in the “Client Service Encounter” screen and tracked as “Monitoring” in the monthly report.

The “**reporting period**” is the calendar month in which the services took place.

- 2) Total number of unduplicated clients served during the reporting period and YTD: A person is counted as an “**unduplicated client**” if a Linkage Case Manager conducts intervention and monitoring activities with, or in some cases on the behalf of, the client.

Please note, rows and columns compiling total number of unduplicated clients served during the month or YTD does not calculate cumulatively since a client may be:

- a. seen multiple times by a provider during the reporting period or YTD;
- b. the recipient of intervention and monitoring activities during the same reporting period; or
- c. referred multiple times to the same type of service

and will not be counted multiple times.

- 3) Total number of direct client hours delivered during the reporting period and YTD. A “**direct client hour**” is the time a provider spends delivering services directly to, or on behalf of, client. The total number of “direct client hours” is the sum of direct service hours delivered as intervention or monitoring activities.
- 4) Percent of clients [linked to HIV medical services](#) during the reporting period and YTD. **Linkage to HIV care** is defined as one (1) face-to-face medical visit with an HIV medical provider, such as the medical doctor, nurse practitioner or physician assistant, within ninety (90) days of the LCM intake and assessment. The percent of clients linked to HIV medical care is calculated by dividing the number of clients linked to HIV medical care by the number of clients served.
- 5) Number of hours devoted to [outreach activities](#) during the reporting period and YTD.
- 6) Total service hours delivered during the reporting period and YTD. The total number of service hours delivered is the sum of hours conducting intervention, monitoring and outreach activities.

It does **not** include time spent on administrative activities, such as program management and oversight, agency meetings, provider trainings, filing, working on client charts, non-client related emails, invoicing, compiling monthly reports, quality assurance activities (including internal chart audits), etc.

- 7) Number of clients referred and linked to the following services during the reporting period and YTD:
- a. HIV medical care
 - b. Mental health services
 - c. Addiction (substance use) treatment
 - d. Housing
- 8) Total number of clients referred and linked to needed services during the reporting period and YTD

Please note, Casewatch will prohibit Linkage Case Managers to enter service delivery data for clients if:

- 1) The client registration is incomplete and/or not completed in Casewatch; and
- 2) The client assessment is not entered into Casewatch.

See Appendix I for a flow chart of Casewatch client registration and data entry rules.

Section IV: Monthly Report Narrative

The report must also include a narrative that describes outreach methods for client recruitment, program challenges, and client linkage. See [Appendix I](#) for a copy of the Report Narrative questions.

Report Submission

In order to submit the monthly report:

- 1) **Ensure all service delivery data for the reporting month is entered.**
- 2) **Generate the monthly report using Casewatch.**
- 3) **Review the monthly report for accuracy** before the agency's designee signs the document. Signature confirms approval and accuracy of reported information. If the report is incorrect, follow up with staff or ACMS to correct any errors.
- 4) **Complete and include the monthly report narrative.**
- 5) **Scan a copy of the signed monthly report and e-mail a copy to the DHSP Program Manager.**
- 6) **Keep an electronic or paper copy of the report for your records** (optional). There are instances when reports may become lost in the mail.
- 7) **Mail or deliver the original signed copy of the monthly report to:**
 - Dave Young, Finance Director
 - Financial Services Division
 - Division of HIV and STD Programs
 - 600 South Commonwealth Avenue, 10th Floor
 - Los Angeles, California 90005

Monthly reports are frequently sent with contract invoices (two copies), since invoices are not processed without receipt of the monthly report. However, some agencies send the monthly report and invoices separately if their programmatic and administrative arms are separate.

Performance Measures

Below is a table of DHSP performance measures for LCM services. These are used to track how well the program is being delivered and determines the threshold for compliance.

Table 7: DHSP performance measures for LCM

Performance Measure	Threshold for Compliance
1.1 Linkage to HIV Care: % of non-medical case management clients linked to an HIV care provider ≤ 6 months of enrolling in NMCM services within the reporting period	85%
2.1 NMCM Assessment Completed: % of clients who have a completed Assessment ≤ 30 days of enrollment in NMCM services within the reporting period	100%
2.2 Disengagement from NMCM : % of clients disengaged from NMCM after ≤ 5 face-to-face brief intervention sessions ≤ 90 days with a non-medical case manager within the reporting period	90%
2.3 Linkage to Housing Programs: % of clients enrolled in a housing program ≤ 45 days of identified housing need in the measurement period	86%
2.4 Provision of Risk Reduction Intervention: % of clients with identified risk behaviors that received the Risk Reduction intervention in the measurement period	100%

Client Charts

All LCM services delivered must be documented in a client chart. Linkage Case Managers should follow the steps below when creating client charts:

- 1) **Ensure the following LCM documents are filed in the client's chart**, preferably in the following order:
 - a. Registration/Intake Documentation, including:
 - i. Documentation of HIV diagnosis
 - ii. Proof of Los Angeles County Residence.
 - iii. Confirmation from client that they have not received HIV care services within the last 7 months.
 - iv. Signed consent to receive LCM services.
 - v. Signed Casewatch consent form.
 - vi. Intake form that lists client name, home address, mailing address, and telephone number; emergency and/or next of kin contact name, home address, and telephone number;

- vii. A signed and dated Release of Information, which is compliant with the Health Insurance Portability and Accountability Act (HIPAA);
 - viii. A signed and dated Limits of Confidentiality in compliance with State and Federal Law;
 - ix. Signed and dated consent to Release Medical Information (if applicable)
 - x. Signed and dated Bill of Rights and Responsibilities document
- b. Assessment
 - c. LTC Plan
 - d. Progress Notes documenting:
 - i. Monitoring activities
 - ii. HIV education activities
 - iii. Risk reduction counseling
 - iv. Service referrals and outcomes, including confirmed linkages

Keep all progress notes current and maintain a copy in the client's file. These notes may be important for future service activities and ensures continuity and consistency in services if a client was transitioned to another provider at your agency.
 - e. Intervention Extension Request and Approval (if applicable)
 - f. Graduated Disengagement Summary Form
 - g. Quality Assurance checklist

2) Neatly maintain and organize the files.

3) Update client information in the LCM file in a timely manner (within twenty-four (24) hours of contact). Memory recall is unreliable after days to weeks have elapsed since the date a contact was made.

File storage and retention

Store all LCM client files according to agency protocol and be consistent with HIPAA policies. At a minimum, the storage system should be a locked file cabinet in a secured room or facility that only LCM and agency staff can access. LCM and agency staff must maintain the confidentiality of all data and records included in the LCM client files and shall comply with state and federal laws, including, but not limited to agency procedures and standards, and DHSP data security and confidentiality requirements.

Contracted agencies must keep the LCM files for at least 7 years after the case has been closed. All closed case files may be destroyed after 7 years or following agency protocol.

Maintaining Client Confidentiality

It is important to ensure that clients' rights to privacy and confidentiality are maintained in the event that client information is released to other providers or agencies for additional services. The Linkage Case Managers should respect clients' right to privacy and only collect information that is essential to provide quality care services. All information about a client and his/her significant others or family members should be held in the strictest confidence.

Information may be released to other professionals and agencies only with the written permission of the client. The Consent to Release Information or Records details what information can be disclosed, to whom it may be disclosed, and for what purpose it will be disclosed. This consent will be reviewed, signed and dated by both the Linkage Case Manager and the client upon enrollment in LCM services. The client has the right

to revoke this release by written request at any time. See [Appendix K](#) for a sample of the Consent to Release Medical Information and the Casewatch consent forms in English and Spanish.

Linkage Case Managers must avoid discussing confidential information in any setting where privacy cannot be ensured, including public or semipublic areas such as hallways, waiting rooms, elevators and restaurants. Linkage Case Managers should also protect the confidentiality of clients' records and other sensitive information, and must take reasonable steps to ensure that client records are stored in a secure location and are unavailable to others who are unauthorized to access them. Linkage Case Managers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Avoid disclosing identifying information whenever possible.

Any person who willfully or negligently discloses a client's HIV status, as defined in Section 120775 of the Public Health and Safety Code, to a third party, in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization, as described in subdivision (g), or except as provided in Section 1603.1 or 1603.3 or any other statute that expressly provides an exemption to this section, that results in economic, bodily, or psychological harm to the subject of the test, is guilty of a misdemeanor, punishable by imprisonment in the county jail for a period not to exceed one year or a fine of not to exceed ten thousand dollars (\$10,000) or both.

While all efforts are taken to maintain client confidentiality, there are certain exceptions. The Notice of Privacy Practices describes these exceptions and states that neither LCM staff nor the LCM site clinic may disclose the client's Protected Health Information (PHI) without the client's permission, except in situations such as: 1) a client harming himself/herself or others; or 2) suspected abuse or neglect of a child or a dependent adult. Inform all LCM clients of these exceptions during enrollment by providing them with a copy of the form and reviewing it with them. See [Appendix L](#) for a copy of this form.

People Living with HIV/AIDS Bill of Rights & Responsibilities

This statement outlines the rights and responsibilities of clients to receive timely services delivered by courteous staff and the client's role in working with the LCM staff, in order to link the HIV care successfully through the LTC Assessment, LTC Plan development and other brief intervention activities. See [Appendix M](#) for the document.

Grievance Procedures

The LCM staff must inform all new LCM clients about the grievance policies and procedures during the enrollment process. Clients will be reminded of the grievance policy if a problem is identified that may result in a grievance such as services being reduced, suspended, denied or terminated, or if a client is dissatisfied with the way services were provided.

The Grievance Policy includes information about DHSP Grievance Line and additional methods of communication:

Phone: 1-800-260-8787

Email: dhspgrievance@ph.lacounty.gov

Web: <http://www.ph.lacounty.gov/dhsp/Grievance.htm>

Address: Attention: QM Grievance Coordinator
600 S. Commonwealth Ave., 10th Floor
Los Angeles, CA 90005

See [Appendix N](#) for a sample Grievance Procedures notification form.

Works Cited

- Abramowitz, S. A., Flattery, D., Franses, K., & Berry, L. (2010). Linking a Motivational Interviewing Curriculum to the Chronic Care Model. *Society for General Internal Medicine*, 25(Suppl 4), 620-6.
- Aidala, A. A., Lee, G., Abramson, D. M., Messeri, P., & Siegler, A. (2007). Housing Need, Housing Assistance, and Connection to HIV Medical Care. *AIDS and Behavior*, 11, 101-105.
- Bangsberg, D. R., Hecht, F. M., Charlesbois, E. D., & et al. (2000). Adherence to protease inhibitors, HIV-1 viral load, and development of drug resistance in an indigent population. *AIDS*, 14, 357-366.
- Berg, M. B., Safren, S. A., Mimiaga, M. J., & et al. (2005). Nonadherence to medical appointments is associated with increased HIV RNA and decreased CD4 cell counts in a community-based HIV primary care clinic. *AIDS Care*, 902-907.
- Braithwaite, R. S., Conigliaro, J., Roberts, M. S., & et al. (2007). Estimating impact of alcohol consumption on survival for HIV+ individuals. *AIDS Care*, 19, 459-466.
- Campbell, N. C., Tross, S., Hu, M., & et al. (2011). Female Condom Skill and Attitude: Results from a NIDA Clinical Trials Network Gender-specific HIV Risk Reduction Study. *AIDS Education and Prevention*, 23(4), 329-340.
- Carey, M. P., & Schroder, K. E. (2002). Development and Psychometric Evaluation of the Brief HIV Knowledge Questionnaire. *AIDS Education and Prevention*, 14(2), 172-182.
- Chander, G., Himelhoch, S., & Moore, R. D. (2006). Substance Abuse and Psychiatric Disorders in HIV-Positive Patients: Epidemiology and Impact on Antiretroviral Therapy. *Drugs*, 66, 769-789.
- Christopoulos, K. D. (2011). Linkage and retention in HIV care among men who have sex with men in the United States. *Clinical Infectious Diseases*, S214-22.
- Cohen MS, C. Y.-M. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine*, 365, 493-505.
- Coleman, S. M., Rajabun, S., Cabral, H. J., & et al. (2009). Sexual risk behavior and behavior change among persons newly diagnosed with HIV: the impact of targeted outreach interventions among hard-to-reach populations. *AIDS Patient Care STDs*, 23, 639-.
- Coury-Doniger, P. A., Levenkron, J. C., McGrath, P. L., & et al. (2000). From theory to practice: Use of stage of change to develop an STD/HIV behavioral intervention. *Cognitive and Behavioral Practice*, 7, 395-406.
- Craw, J. G. (2008). Brief strengths-based case management promotes entry into HIV medical care: results of the antiretroviral treatment access study-II. *Journal of Acquired Immune Deficiency Syndromes*, 597-606.
- Craw, J. G. (2010). Structural factors and best practices in implementing a linkage to HIV care program using the ARTAS model. *BMC Health Services Research*.
- Crystal S., S. U. (2001). Initiation and continuation of newer antiretroviral treatments among medicaid recipients with AIDS. *Journal of General Internal Medicine*, 850-859.
- DHHS. (2012). *Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. Retrieved September 26, 2012, from <http://aidsinfo.nih.gov/guidelines/>: <http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf>
- Division of HIV and STD Programs. (2012). *Policy Brief: HIV Prevention Through Care and Treatment*. Los Angeles: Los Angeles County Department of Public Health.
- Ernst, A. A., Weiss, S. J., & Cham, E. (2004). Detecting Ongoing Intimate Partner Violence in the Emergency Department Using a Simple 4-Question Screen: The OVAT. *Violence and Victims*, 19(3), 375-384.
- Fisher, J. D., Fisher, W. D., Cornman, D. H., & et al. (2006). Clinician-Delivered Intervention During Routine Clinical Care Reduces Unprotected Sexual Behavior Among HIV-Infected Patients. *Journal of Acquired Immunodeficiency Syndrome*, 41(1), 44-52.
- Fleishman, J. A., Moore, R. D., Conviser, R., & et al. (2008). Associations between outpatient and inpatient service use among personal with HIV infection: a positive or negative relationship? *Health Serv Res*, 43, 76-95.
- Gardner, E. M. (2011). The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. *Clinical Infectious Diseases*, 793-800.
- Gardner, L. M.-M. (2005). Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS*, 423-431.
- Giordano T.P., G. A.-A. (2007). Retention in care: a challenge to survival with HIV infection. *Clinical Infectious Diseases*, 1493-1499.

- Giordano T.P., H. C. (2009). Predictors of retention in HIV care among a national cohort of US veterans. *HIV Clinical Trials*, 299-305.
- Giordano, T. P. (2011). Retention in HIV care: what the clinician needs to know. *Topics in Antiviral Medicine*, 19(1), 12-16.
- Hall, H. G. (2012). Retention in care of adults and adolescents living with HIV in 13 U.S. areas. *Journal of Acquired Immune Deficiency Syndromes*, 77-82.
- Hammond, W. a. (2012). *A Strengths-Based Perspective*. Calgary: Resiliency Initiatives.
- Health Resources and Services Administration. (2011). *Guide for HIV/AIDS Clinical Care*. Retrieved from <http://hab.hrsa.gov/deliverhivaidscares/clinicalguide11/>: <http://hab.hrsa.gov/deliverhivaidscares/clinicalguidelines.html>
- Health Resources and Services Administration, HIV/AIDS Bureau. (2006). *Outreach: Engaging People in HIV Care: Summary of a HRSA/HAB 2005 Consultation on Linking PLWH Into Care*. Health Resources and Services Administration.
- Higa, D. M. (2012). Interventions to improve retention in HIV primary care: a systematic review of U.S. studies. *Current HIV/AIDS Reports*, 313-25.
- HIV Epidemiology Program, L. A. (2009). *An Epidemiologic Profile of HIV and AIDS in Los Angeles County*.
- House, T. W. (2010). *National HIV/AIDS Strategy for the United States*. Washington D.C.: White House.
- Kalichman, S. C., Cherry, C., White, D., & et al. (2011). Sexual HIV Transmission and Antiretroviral Therapy: A Prospective Cohort Study of Behavioral Risk Factors Among Men and Women Living with HIV/AIDS. *Annals of Behavioral Medicine*, 41(1), 111-119.
- Katz, S., Ford, A. B., Moskowitz, R. W., & et al. (1983). Studies of illness in the aged. The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association*, 185, 914-919.
- Klinkenberg, W. a. (2004). Mental disorders and drug abuse in persons living with HIV/AIDS. *AIDS Care*, 16 (Supplement 1), S22-S42.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.
- Lawton, M. P., & Brody, E. (1969). Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *The Gerontologist*, 9, 179-186.
- Liegal, B. (2006). How to make the care management model work. A case study. *The Case Manager*, 5(2), 51-54.
- Lucas, G. M., Chaisson, R. E., & Moore, R. D. (1999). Highly active antiretroviral therapy in a large urban clinic: risk factors for virologic failure and adverse drug reactions. *Ann Intern Med*, 131, 81-87.
- Macharia, W. M., Leon, G., Rowe, B. H., & et al. (1992). An overview of interventions to improve compliance with appointment keeping for medical services. *JAMA*, 267(10), 1813-17.
- Mathews, C., Coetzee, N., Zwarenstein, M., & et al. (2002). A systematic review of strategies for partner notification for sexually transmitted diseases, including HIV/AIDS. *International Journal of STD & AIDS*, 13, 285-300.
- McGowan, J. P., Shaw, S. S., Ganea, C. E., & et al. (2004). Risk Behavior for Transmission of Human Immunodeficiency Virus (HIV) among HIV-Seropositive Individuals in an Urban Setting. *Clinical Infectious Diseases*, 38, 122-27.
- Metsch, L., Pereyra, M., Messinger, S., & et al. (2008). HIV Transmission Risk Behaviors among HIV-Infected Persons Who Are Successfully Linked to Care. *Clinical Infectious Diseases*, 47, 577-84.
- Mugavero, M. A. (2012). Early retention in HIV care and viral load suppression: implications for a test and treat approach to HIV prevention. *Journal of Acquired Immune Deficiency Syndromes*, 86-93.
- Mugavero, M. A. (2013). The State of Engagement in HIV Care in the United States: From Cascade to Continuum to Control. *Clinical Infectious Diseases*, 1-8.
- Mugavero, M. J., Lin, H. Y., Allison, J. J., & et al. (2005). Racial disparities in HIV virologic failure: do missed appointments matter? *JAIDS*, 19, 423-431.
- Mugavero, M. J., Lin, H. Y., Willig, J. H., & et al. (2009). Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clinical Infectious Diseases*, 48, 248-256.
- Office of National AIDS Policy. (2013). *National HIV/AIDS Strategy - Improving Outcomes: Accelerating Progress Along the HIV Care Continuum*. Washington, D.C.
- Osborn, C. Y., Davis, T. C., Bailey, S. C., & Wolf, M. S. (2010). Health Literacy in the Context of HIV Treatment: Introducing the Brief Estimate of Health Knowledge and Action (BEKHA)-HIV Version. *AIDS and Behavior*, 14, 181-188.

- Owens, M., Wollersheim, H., Hermens, R., & et al. (2005). Integrated care programmes for chronically ill patients: A literature review. *International Journal for Quality in Health Care*, *17*(2), 141-149.
- Paterson, D. L., Swindells, S., Mohr, J., & et al. (2000). Paterson DL, Swindells S, Mohr J, Brester M, Vergis EN, Squier C et al. Adherence to protease inhibitor therapy and outcomes in patients with HIV infection. *Annals of Internal Medicine*, *133*, 21-30.
- Prochaska, J. O., & DiClemente, C. C. (1982). Stages and Process of Self-Change of Smoking: Towards an Integrative Model of Change. *Journal of Consulting and Clinical Psychology*, *51*, 390-395.
- Prochaska, J. O., & Velicer, W. F. (1997). Misinterpretations and misapplications of the transtheoretical model. *American Journal of Health Promotion*, *12*, 11-12.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*(47), 1102-14.
- Prochaska, J. O., Redding, C. A., & Evers, K. E. (1997). The Transtheoretical Model and Stages of Change. In L. F. Glanz K (Ed.), *Health Behavior and Health Education: Theory, Research and Practice* (2nd ed., pp. 66-84). San Francisco, CA: Jossey-Bass Inc.
- Rajabiun, S. M. (2007). "Getting Me Back on Track": The Role of Outreach Interventions in Engaging and Retaining People Living with HIV/AIDS in Medical Care. *AIDS Patient Care and STDs*, S20-S29.
- Rollnick, S. &. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*, 325-334.
- Rosen, S. L., & Reuben, D. B. (2011). Geriatric Assessment Tools. *Mt Sinai J Med*, *78*(4), 489-97.
- Saliba, S., Elliott, M., Rubenstein, L., & et al. (2001). The Vulnerable Elders Survey (VES-13): A Tool for Identifying Vulnerable Elders in the Community. *Journal of the American Geriatric Society*, *49*, 1694-1699.
- Sethi, A. K., Celentano, D. D., Gange, S. J., & et al. (2003). Association between Adherence to Antiretroviral Therapy and Human Immunodeficiency Virus Drug Resistance. *Clinical Infectious Diseases*, *37*, 1112-8.
- Sherbourne, C. D., & Stewart, A. L. (1991). The MOS Social Support Survey. *Soc Sci. Med.*, *32*(6), 705-714.
- Sherer, R., Stieglitz, K., Narra, J., & et al. (2002). HIV multidisciplinary teams work: support services to improve access to and retention in HIV care. *AIDS Care*, S31-44.
- Simoni, J. M., Amico, K. R., Pearson, C. R., & Malow, R. (2008). Strategies for Promoting Adherence to Antiretroviral Therapy: A Review of the Literature. *Current Infectious Disease Reports*, *10*, 515-521.
- Soto, T. B. (2004). Literature on integrated HIV care: a review. *AIDS Care*, *16* (Supplement 1), S43-S55.
- Spitzer RL, K. K., Spritzer, R. L., Kroenke, K., Williams, J. B., & et al. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, *166*, 1092-1097.
- Stoff, D. M., Mitnick, L., Kalichman, S., & et al. (2004). Research issues in the multiple diagnoses of HIV/AIDS, mental health illness and substance abuse. *AIDS Care*, *16* (Supplement 1), S1-S5.
- Swedeman, D., Ingram, B., & Rotheram-Borus, M. J. (2009). Common elements in self-management of HIV and other chronic illnesses: an integrative framework. *AIDS Care*, *21*(10), 1321-1334.
- Syed, S. G. (2013). Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health*, 976-993.
- Thompson, M. M. (2012). Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: evidence-based recommendations from an International Association of Physicians in AIDS Care panel. *Annals of Internal Medicine*.
- Tobias, C. R., Cunningham, W., Cabral, H. D., & et al. (2007). Living with HIV but without medical care: barriers to engagement. *AIDS Patient Care and STDs*, *21*, 426-34.
- Tucker, J. S., Burnham, M. A., Sherbourne, C. D., & et al. (2003). Substance Use and Mental Health Correlates of Nonadherence to Antiretroviral Mediations in a Sample of Patients with Human Immunodeficiency Virus. *American Journal of Medicine*, *114*, 573-580.
- UCSF AIDS Health Project, & Office of AIDS. (2008). Building Quality HIV Prevention Counseling Skills: The Basic I Training for Counselors II Staff Working in HIV Counseling and Testing - Participant's Manual. San Francisco: UCSF AIDS Health Project.
- Ulett, K. B., Willig, J. H., Lin, H., & et al. (2009). The therapeutic implications of timely linkage and early retention in HIV care. *AIDS Patient Care and STDs*, *23*(1), 41-49.
- Valverde, E. W.-V.-M. (2006). System and Patient Barriers to Appropriate HIV Care for Disadvantaged Populations: The HIV Medical Care Provider Perspective. *Journal of the Association of Nurses in AIDS Care*, 18-28.

- Variable, P. A., Carey, M. P., Blair, D. C., & Littlewood, R. A. (2006). Impact of HIV-Related Stigma on Health Behaviors and Psychological Adjustment Among HIV-Positive Men and Women. *AIDS and Behavior, 10*(5), 473-482.
- Wagner, G., Kanouse, D. E., Golinelli, D., & et al. (2006). Cognitive-behavioral intervention to enhance adherence to antiretroviral therapy: a randomized controlled trial (CCTG 578). *AIDS, 20*, 1295-1302.
- Walensky, R. P., Paltiel, A. D., Losina, E., & et al. (2006). The survival benefits of AIDS treatment in the United States. *Journal of Infectious Diseases, 194*(1), 11-19.
- Washington State Department of Health. (2004). *System Acuity Measurement for HIV Care Case Management*. Olympia: Washington State Department of Health.
- Wilson, P. (2006). Medical case management: A look at the Ryan White HIV/AIDS Treatment Modernization Act of 2006. *The 19th Annual National Conference on Social Work and HIV/AIDS*. Albuquerque, New Mexico.
- Wohl, A. R., Galvan, F. H., Myers, H. F., & et al. (2011). Do Social Support, Stress, Disclosure and Stigma Influence Retention in HIV Care for Latino and African American Men Who Have Sex with Men and Women? *AIDS and Behavior, 15*, 1098-1110.
- Wohl, A. T. (2009). Factors associated with late HIV testing for Latinos diagnosed with AIDS in Los Angeles County. *AIDS Care, 12*03-1210.

APPENDICES

Appendix A: Stages of Change

Appendix B: Motivational Interviewing Techniques

Appendix C: LTC Assessment

Appendix D: LCM Consent Form

Appendix E: Sample of LTC Plan Template

Appendix F: DHSP Intervention Extension Request Form

Appendix G: Graduated Disengagement Summary Form

Appendix H: Linkage Case Management Client Follow-Up Status Form

Appendix I: Flow Chart of Casewatch Client Registration and Data Entry Rules

Appendix J: Section IV: Monthly Report Narrative Form

Appendix K: Consent to Release Medical Information

Casewatch consent forms in English and Spanish

Appendix L: Sample Notice of Privacy Practices

Appendix M People Living with HIV/AIDS Bill of Rights & Responsibilities

Appendix N: Sample Grievance Procedures Notification Form

Appendices may also be accessed in the DHSP website.

Appendix A: Stages of Change

The Stages of Change is a model many providers use to guide their choice of appropriate interventions once the patient's stage of change is properly assessed. To most effectively advance the patient's progress from their current stage to the next, interventions should be carefully stage-matched. Below is a table associating each stage of change with common patient characteristics and intervention strategies (UCSF AIDS Health Project & Office of AIDS, 2008).

Stage	Characteristics	Interventions
PRECONTEMPLATIVE	Unaware Defensiveness Resistance	Engagement Trust Building Get a reaction, either cognitive or Emotional
CONTEMPLATIVE	Ambivalence, unsure Problem awareness Openness to information	Help explore ambivalence Explore barriers Pass information
READY FOR ACTION (PREPARATION)	Ready to do Experimentation	Encourage, empower, support Emphasize options Coaching; teaching skills Focus on developing a step
ACTION	Practice new behaviors Avoiding old behaviors	Support, praise, recognition Focus on rewards Follow-up, reach out Problem-solving
MAINTENANCE	Sustaining behavior	Reinforcement Support, praise, recognition Find other supports Become a role model to others

*Chart taken from UCSF AIDS Health Project and Office of AIDS, California Department of Public Health. *Building Quality HIV Prevention Counseling Skills: The Basic I Training for Counselor II Staff Working in HIV Counseling and Testing—Participant's Manual*. San Francisco: UCSF AIDS Health Project, 2008.

Appendix B: Motivational Interviewing Techniques

Specific MI techniques used to accomplish behavior change include **OARS** (open-ended listening, affirmations, reflective listening and summarizing) and “change talk.” These techniques are described in detail below.

- **O**pen-ended questions are those questions which are not easily answered with a one-word response (“yes” or “no”) and do not assert the provider’s values or objectives.

Example:

Close-ended question: “Do you know how people get HIV?”

Open-ended question/elicitation: “Tell me what you know about HIV.”

- **A**ffirmations are a way of verbally validating a patient’s thoughts, emotions or actions. They help build self-efficacy by highlighting past or present strengths, efforts or intentions that the patient has demonstrated but may not have recognize or acknowledge. Affirmations may also be posed as a question to encourage patients to self-identify what has been going well.

Example:

Patient: *I don’t know why I feel so overwhelmed. My husband has a real job and works long hours—nearly 60 hours a week! I just stay at home with the kids, cook and clean.*

Provider: *“You spend a lot of time taking care of the household. It sounds like your husband depends on you to raise the children and keep the family organized.” or “How do you feel about what you’ve accomplished?”*

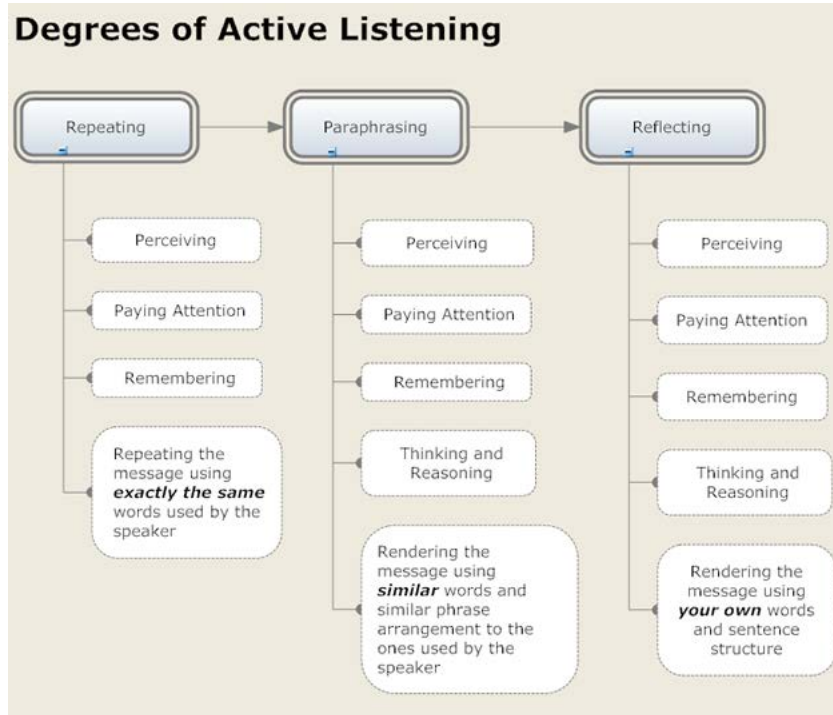
- **R**eflective listening is a way of clarifying, amplifying or guessing the meaning behind what the patient is saying. There are three levels of reflective listening: parroting, paraphrasing and reflection.
 - **Repeating (or parroting):** repeating the patient’s words exactly. When used sparingly, this technique can help the patient feel heard.
 - **Paraphrasing:** repetition of the gist of patient’s feelings by the provider in their own words.
 - **Reflection:** seeks to identify deeper feelings that are unsaid but lie beneath what is literally said. Reflecting statements are *validating* statements and, by allowing the patient to hear his/her words in another person’s voice, may help to clarify patient’s feelings.

Example:

Patient: *“I know I should use condoms, but honestly, I just don’t feel a connection when I use them.”*

Provider responds: *“You don’t feel intimacy with your partner when condoms are involved.”*

It is easy to confuse the purpose of “repeating,” “paraphrasing” and “reflection.” Below is a graph clarifying the subtle differences between the three techniques.



- **S**ummarizing highlights the most important aspects of what has been discussed. At the same time, providers are giving the “gist” of what was heard and checking for accuracy.

Example:

Patient: *"Last month I had sex with Todd and never told him my status. I felt awful. Now he wants to get together seriously and I don't know what to do."*

Provider summarizes by saying: *"Not telling Todd your status made you feel guilty because you felt you weren't being honest with him. This has made it difficult for you to move forward with a potential relationship."*

Change Talk invites the patient to make the argument for change by eliciting types of statements that indicate readiness to change. Types of change talk are categorized as follows:

- Desire to change (I want...)
- Ability to change (I can...)
- Needs to change (I should...)
- Commitment to change (I will...)
- Reason to change (it's important because...)

The acronym DANCR is frequently used to refer to these five categorizes of change talk.

⁸ Citation unknown. Last accessed on October 31, 2012 from: http://en.wikipedia.org/wiki/Active_listening.

DHSP Linkage Case Management: Assessment

CLIENT NAME: _____

CASEWATCH CIS#: _____

LINKAGE CM NAME: _____

ASSESSMENT DATE: / /
 M M D D Y Y Y Y

HIV CARE STATUS (check one): [0] Never in HIV Care [1] Previously in HIV Care

(READ): I am going to ask you some questions about yourself to help me better understand how we can work together to get the health and support services you may need. Some of the questions I ask may be personal. You do not have to answer any questions you feel are too personal or that make you uncomfortable, but your answers will help me to better understand your strengths and needs.

1. When did you first test positive for HIV?: /
 M M Y Y Y Y

2. How important is it for you to see an HIV doctor?
[1] Not at all important [2] Somewhat Important [3] Extremely Important

3. Have you ever seen a doctor for your HIV?
[1] Yes [in the past -previously in care]
[0] No [has never seen an HIV doctor] → Go to Q.12
[9] Don't know/Refuse to answer → Go to Q.12

3a. If YES: When was the last time you saw your HIV doctor?

Date of most recent visit: /
 M M Y Y Y Y

IF YES TO Q 3 [PREVIOUSLY IN CARE], THEN ASK:

4. Is it difficult for you to see your HIV doctor as often as you are supposed to?
[1] Yes [0] No

5. What types of things got in the way or made it difficult for you to see your doctor as often as you are supposed to? (Select all that apply)

[1] Disclosure
Did not want to tell partner about my HIV
Did not want to tell family about my HIV

[2] Living Situation
Was homeless
Worried about my immigration status
Was in jail or prison
Was living back and forth between U.S. and other country

[3] Substance Use
Was using drugs and/or alcohol

[4] Clinic Location

Lacked transportation to get to the clinic
Could not easily get to the clinic location

[5] Childcare

Child care was not available at the clinic

[6] Cost of HIV care/no insurance

Did not have No insurance
Could not afford the cost of care

[7] Access to HIV Provider

Had to wait too long to get an appointment
Takes too long to get another appointment if you miss one
Had to wait too long in the clinic to be seen
Could not get to the clinic during the hours it was open
Did not have all of the required paperwork to see the HIV doctor
Could not take time off of work

[8] Fear

Did not feel comfortable being around other patients at the clinic
People at the clinic would know or recognize me
Did not trust of the medical system

[9] Stigma

Did not want to take time off of work because my employer might find out I have HIV
Worried someone would find out I have HIV
Worried people would think badly of me because I have HIV

[10] Clinic Staff or Setting

Clinic staff was not friendly or helpful
Couldn't find a HIV healthcare provider I liked
Did not feel culturally accepted at the clinic
Did not like the clinic (e.g., too hot/cold, too dirty, in a bad neighborhood)

[11] Heath Status

Felt too sick to go to the clinic
Felt well or had no symptoms
Not ready to start taking HIV medications

[12] Other: _____

7a. Of the reasons you told me, which do you think is the main reason keeping you from seeing an HIV doctor?

Reason #: _____ [select main reason from Q7 if more than one]

8. Where did you go the last time you saw your HIV doctor: _

Provider name: _____ [use drop down list of providers in Casewatch]

9. How many times have you seen your HIV doctor in the past 12 months? _____

10. Do you want to go back to that HIV doctor/clinic for your HIV care?

[0] No → Skip to Q. 11 [1] Yes [9] Don't know/refused → Skip to Q.11

10a. If no, why do you not want to go back? (Select all that apply)

[1]	Don't like doctor	[5]	Have to wait too long for an appointment
[2]	Don't like office staff	[6]	Did not feel like I needed it
[3]	Clinic is too far away	[7]	I do not want to deal with this right now.
[4]	Don't speak my language	[8]	Other: _____

11. Have you ever been prescribed medications for HIV?

[1] Yes → GO to Q. 11a [0] No → SKIP to Q. 12 [9] Don't know/Refuse to answer → SKIP to Q. 12

11a. Are you currently taking medications for HIV?

[1] Yes [0] No [9] Don't know/Refuse to answer

ASK OF ALL PATIENTS [never in care AND previously in care]:

(READ ALOUD): I am going to work with you to get you connected to a clinic so that you can get medical and social support to help you stay healthy.

12. What, if any, are the types of things that you need immediate help with for you to see an HIV doctor? (Select all that apply)

[1] Disclosure

I need to tell my partner about my HIV status
I need to tell my family about my HIV status

[2] Living Situation

I am homeless and I need stable housing
I am worried about my immigration status

[3] Substance Use

I am actively using drugs and/or alcohol, which interferes with my daily activities
I need help to stop using drugs and/or alcohol

[4] Clinic Location

I do not have transportation to get to the clinic
I cannot get to the clinic location easily

[5] Childcare

I need someone to take care of my child/children so I can go to the clinic

[6] Cost of HIV care/no insurance

I do not have medical insurance
I do not think I can afford the cost of care

[7] Access to HIV Provider

I cannot get to the clinic during the hours it is open
I do not have all of the required paperwork to see the HIV doctor
I cannot take time off of work
I do not know if I can take time off of work

[8] Fear

I do not feel comfortable being around other patients at the clinic
I am scared people at the clinic would know or recognize me
I do not trust of the medical system

[9] Stigma

I do not want to take time off of work because my employer might find out I have HIV
I am worried someone would find out I have HIV
I am worried people would think badly of me because I have HIV

[10] Mental Health Status

I need to see a doctor to get medication for my mental health
I have been feeling sad or upset recently
I get stressed thinking about going to the doctor

[11] Health Status

I feel okay no symptoms
I am not ready to start taking HIV medications

[12] Other: _____

[13] I don't need help with anything to see an HIV doctor

(READ ALOUD): As part of the assessment, I ask all patients about their mental health and any counseling or mental health services they may have received in the past 6 months. You don't have to answer any questions you feel are too personal.

13. In the past 6 months, have you experienced any emotional issues that got in the way of your daily routine or the usual things that you do?
 [1] Yes [0] No [9] Don't know/Refuse to answer

14. In the past 6 months, have you been in mental health therapy or seen a psychiatrist?
 [1] Yes [0] No → Skip to Q15 [9] Don't know/Refuse to answer → Skip to Q15

14a. When did you last see a mental health therapist or a psychiatrist (month and year)?

____/____
 M M Y Y Y Y

14b. Where did you last see a mental health therapist or psychiatrist? _____

(READ ALOUD): "The next questions I ask are about things that might have bothered you in the past 6 months. For each question, please tell me which answer best describes how much (or how often) you have been bothered by each problem during the past SIX (6) MONTHS." (Show Response Card)

During the past SIX (6) MONTHS, how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Mode rate More than half the days	Sev ere Near ly ever y day	Highest Domain Score (clinician)
15. Little interest or pleasure in doing things?	0	1	2	3	4	
16. Feeling down, depressed, or hopeless?	0	1	2	3	4	
17. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
18. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
19. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
20. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
21. Feeling panic or being frightened?	0	1	2	3	4	
22. Avoiding situations that make you anxious?	0	1	2	3	4	
23. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
24. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
25. Thoughts of actually hurting yourself?	0	1	2	3	4	
26. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
27. Feeling that someone could hear your	0	1	2	3	4	

thoughts, or that you could hear what another person was thinking?						
28. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
29. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
30. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
31. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
32. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
33. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
34. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
35. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
36. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
37. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

READ: "Now I'd like to ask you a few questions about the types of people you have relationships with. These may be family, friends or other people".

38. Have you used drugs or alcohol in the past 6 months?
 [1] Yes [0] No → Skip to Q40 [9] Don't know/Refuse to answer → Skip to Q40

39. Have you injected any drugs in the past 6 months?
 [1] Yes [0] No → Skip to Q40 [9] Don't know/Refuse to answer → Skip to Q40

39a. If YES, did you share any of your injection equipment?
 [1] Yes [0] No [9] Don't know/Refuse to answer

40. Are you currently trying to reduce or stop your drug or alcohol use?
 [1] Yes [0] No [9] Don't know/Refuse to answer

READ: "Now I'd like to ask you a few questions about yourself and your partner(s)".

41. Are you single, married, in a committed relationship, separated, divorced or widowed? [Read all responses and check only one]
 [1] Single, never married [5] Married
 [2] Divorced [6] Other: _____
 [3] Widowed [7] Don't know/Refuse to answer
 [4] Partnered or in a relationship

42. Do you consider yourself to be... [Check only one]
- | | | | |
|-------|-------------------------|-------|-----------------------------|
| [1] | Gay/Lesbian | [4] | Other: _____ |
| [2] | Bisexual | [5] | Don't know/Refuse to answer |
| [3] | Straight (Heterosexual) | | |

43. During the past 6 months have you had vaginal or anal sex with a partner?
 [1] Yes [0] No → Go to Q. 44 [9] Don't know/Refuse to answer

43a. During the past 6 months, how many different sexual partners did you have? # _____

43b. Tell me how many of those partners did you NOT use condoms with? # _____

43d. How many of those partners did you tell your HIV status to? # _____

44. Have you been diagnosed with any sexually transmitted disease in the past 12 months?
 [1] Yes [0] No [9] Don't know/Refuse to answer

(READ ALOUD): "I am going to now ask you some questions about your living situation."

45. Where are you currently living? [Check all that apply]

[1] Rental unit alone	→ go to Q 47
[2] Single Room Occupancy hotel (SRO)	
[3] Own Home	
[4] Live with friend	
[5] Live with family	
[6] Live with partner	
[7] Group/Foster home	
[8] Supportive housing	
[9] Transitional Housing	
[10] Hotel/Motel	
[11] Living temporarily with friend(s)	
[12] Living temporarily with family	
[13] Other housing: _____	
[14] Car	HOMELESS → go to next question
[15] Outside/Street	
[16] Shelter	
[17] Abandoned/vacant building	
[18] Other homeless: _____	
[19] Don't know/Refuse to answer	

If patient is currently homeless:

46. How long have you been homeless? _____ weeks

46a. Where do you... i. sleep? _____

ii. eat? _____

iii. hang out? _____

47. Thank you for answering all of my questions. Is there anything else that I have not asked you about that you think would help you to see an HIV care provider?

[] No

[] Yes, describe: _____

<u>Summary Notes:</u>

Linkage Case Manager Signature

LCM _____

Date ____ / ____ / ____

Appendix E: Sample of LTC Plan Template

GOAL: LINK TO HIV MEDICAL SERVICES

OBJECTIVE (what) _____

ACTION STEPS (how)	RELATED STRENGTHS	POTENTIAL BARRIERS	WHO IS RESPONSIBLE?	TIME FRAME	DISPOSITION (progress)

OBJECTIVE (what) _____

ACTION STEPS (how)	RELATED STRENGTHS	POTENTIAL BARRIERS	WHO IS RESPONSIBLE?	TIME FRAME	DISPOSITION (progress)

ARE OBJECTIVE(S):

- Specific** – What does client want to do, by when, with who, and how much (to what degree)?
- Measurable** – Can the client/provider measure progress towards the objective? How will you know if the objective is reached or accomplished?
- Achievable/Attainable** – Can the client realistically achieve the outcome given their time frame, resources, and ability?
- Relevant** – Does it align with the goal of linking to HIV medical services?
- Time** – Is the time frame realistic?

Client Signature _____

LCM Signature: _____

Date: _____

Date: _____

Appendix F: DHSP Intervention Extension Request Form

Appendix G: Graduated Disengagement Summary Form

Client Name: _____ ID: _____

On _____ (mm/dd/yyyy) the above client was disengaged from the LCM program due to:

- Relocation outside of Los Angeles County
- Completion of maximum number of LCM sessions **without being linked** to HIV medical care
- Request to no longer be part of the LCM program
- Lost to follow-up/unable to locate
- Incarceration
- Other: _____

Linked to HIV medical care at:

HIV/AIDS Clinic: _____ Phone: _____

Contact Name: _____

Address: _____ Medical Visit date: _____

Comments:

Linkage Case Manager Signature: _____ Date: _____

Linkage Case Manager Name (Printed): _____ Date: _____

Supervisor Signature: _____ Date: _____

Supervisor Name (Printed): _____ Date: _____

Linkage Case Management Client Follow-Up Status

Form must be completed and data must be entered into Casewatch ninety (90) days after client has been disengaged from the LCM program.

Client Name: _____ Follow-Up Date: _____

Client **WAS CONTACTED** at 90 days (select one):

- In face-to –face meeting
- By phone
- By email

Client was **NOT** contacted at 90 days because:

- Client lost to follow-up/unable to locate
- Client is incarcerated

Client Status:

Client **WAS LINKED** to Medical Care. (Client saw an HIV primary care physician):

At the following clinic: _____

Was a Viral Load Test Completed? Yes: Viral Load Value _____copies/mL

No

Was patient prescribed ART? Yes No

Client went to the above HIV Medical Clinic but client did not see an HIV primary care physician

Client **NOT LINKED** to Medical Care (did not see an HIV primary care physician) for the following reason(s):

- Living Situation Substance Use Transportation Stigma Felt fine
- Mental Health Issues Working Childcare Disclosure Other

Client interested in attending a medical appointment with an HIV primary care physician?

Yes LCM referred client to: _____

Yes, but not now No Client is Unsure

Linkage Case Manager Signature: _____ Date: _____

Appendix I: Flow Chart of Casewatch Client Registration and Data Entry Rules

Please see DHSP website for link to chart.



County of Los Angeles - Department of Public Health
Division of HIV and STD Programs
600 South Commonwealth Avenue, 10th Floor
Los Angeles, California 90005
(213) 351-8000



Section IV - Monthly Narrative Questionnaire
Linkage Case Management Monthly Progress Report

During the reporting month:

1. How were clients recruited for your Linkage Case Management program? From where were they referred?

2. Which outreach strategies were most effective in recruiting clients for your Linkage Case Management Program?

3. What outreach activities did your program staff conduct?

4. Describe any challenges in getting clients to enroll into your agency's Linkage Case Management program.

5. List the name of clinics to which your Linkage Case Management program:
 - a. referred clients; and
 - b. linked clients for HIV medical care.

6. Describe any challenges your program staff encountered when attempting to link clients to clinics for HIV medical care, e.g., were there clinic policies, procedures or staff that made it difficult for your clients to link successfully? Was it difficult to confirm client linkage with the clinic(s)?

**AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION**

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:

(Note: “at the request of the patient” is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.⁹
- Only the following records or types of health information:
_____.

Term: I understand that this Authorization will remain in effect:

- From the date of this Authorization until the _____ day of _____, 20____.
- Until the Provider fulfills this request.
- Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be

⁹ NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at USC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the USC Office of Compliance for answers to my questions about the privacy of my health information at 3500 Figueroa, Suite 105, Los Angeles, CA 90089-8007, or by telephone at (213) 740-8258.

_____	_____	_____
Signature Witness	Date	Signature of

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness



Division of HIV and STD Programs
www.publichealth.lacounty.gov/aids

Casewatch Millennium® Client Consent Form



I, _____, (print full name) wish to register with Ryan White Program/Casewatch Millennium® in order to receive services funded by the Ryan White Program or the Department of Public Health (DPH), Division of HIV and STD Programs (DHSP). During registration, I will be asked to provide information about myself, including my name, race, gender, birth date, income and other demographic data. Depending upon the agency or program I am registering with, I may also be asked questions about my CD4 cell count, viral load, use of HIV medications, risk behaviors, my general physical and medical condition and medical history.

In addition to providing information, I will provide an original letter of diagnosis signed and dated by my doctor, or have a blood test that shows that I am HIV positive. By signing this form, I verify that I reside in Los Angeles County.

I understand that certain services may be available to HIV-negative partners, family members, or other caregivers affected by HIV, and registration and service information for these clients will not be shared between agencies regardless of my own share status. I understand that my name and information will not be shared outside the Ryan White Program/Casewatch Millennium® system unless I provide my specific, informed consent for such a disclosure. A list of Ryan White Program/Casewatch Millennium® agencies is available upon request.

Additionally, as a condition of receiving Ryan White Program services, I agree that my information will be made available to my local health department, to fiscal agents that fund services I receive, to DPH/DHSP, and to the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) for mandated care and treatment reporting, program monitoring, statistical analysis and research activities. This information includes the minimum necessary, but is not limited to gender, ethnicity, birth date, zip code, diagnosis status, and service data. No identifying information, such as name and social security number, will be released, published, or used against me without my consent, except as allowed by law.

By checking the "I AGREE and UNDERSTAND" box below, I understand that my relevant health, including HIV status, and income information will be shared with my local health department, fiscal agents that fund services I receive, the Department of Public Health, Division of HIV and STD Programs, and the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) when I request enrollment in care or access to services at a Ryan White Program agency. Only authorized personnel at each agency will have access to my information on a need-to-know basis. The information shared may include information about services received or my treatment at a particular agency. Mental health, legal and/or substance abuse services will only be shared as allowed by law. In most cases, I will not need to re-register (in Casewatch Millennium®) or provide a letter of HIV diagnosis when I require services from an agency providing services funded by the Ryan White Program or the DPH/Division of HIV and STD Programs.

[] I AGREE AND UNDERSTAND

My registration in Ryan White Program/Casewatch Millennium® does not guarantee services from any agency. Waiting lists or eligibility requirements may exclude me from services at other Ryan White Program/Casewatch Millennium® agencies.

By signing this form I acknowledge that I have been offered a copy of this consent form, and have discussed it with the staff person indicated below. I understand that this form will be stored in my paper file and that this consent form remains in effect for three (3) years from the date I sign this form.

Signature of Client or Parent/Guardian of Minor Child

Date

DHSP 12-001 (Rev 6/2012)



Division of HIV and STD Programs
www.publichealth.lacounty.gov/aids

Casewatch Millennium®
Consentimiento del Cliente



Yo, _____, (*nombre en letra de molde*) deseo inscribirme con el "Ryan White Program/Casewatch Millennium®" para recibir servicios del Programa del Ryan White o del Departamento de Salud Pública (DPH), División de Programas de VIH y ETS (DHSP). Al registrarme me pedirán información personal, incluyendo mi nombre, raza, género, fecha de nacimiento, ingreso y otra información demográfica. Dependiendo de la agencia o programa con el que me inscribo, también me pueden preguntar sobre mi recuento de células CD4, carga viral, uso de medicamentos para el VIH, comportamientos de riesgo, mi condición general física y médica e historial médico.

Además de proveer información, proveeré una carta original de mi diagnóstico firmada y fechada por mi doctor, o me haré una prueba de sangre que muestre que soy VIH positivo. Al firmar este formulario, verifico que resido en el Condado de Los Angeles.

Entiendo que hay ciertos servicios disponibles para parejas VIH-negativas, miembros de la familia, u otras personas a cargo afectados por el VIH, y la registración e información sobre servicios para estos clientes no será compartida con otras agencias independientemente de mi decisión de compartir mi información. Entiendo que mi nombre e información no será compartida fuera del sistema de Ryan White Program/Casewatch Millennium® a menos que yo provea un consentimiento específico para tal revelación. Una lista de agencias de Ryan White Program/Casewatch Millennium® está disponible a petición.

Además, como condición de recibir servicios del Programa de Ryan White, doy mi consentimiento para que mi información se ponga a disposición del departamento de salud local, agentes del fisco que proveen fondos para los servicios que recibo, a DPH/DHSP, y al Departamento de Salud Pública del Estado de California (CDPH), Oficina del SIDA del Estado de California, Sistema Regional de Información y Evaluación del SIDA (ARIES) para la presentación de informes obligatorios sobre el tratamiento y cuidado, monitoreo del programa, análisis estadístico y actividades de investigación. Esta información incluye el mínimo necesario, pero no se limita al género, origen étnico, fecha de nacimiento, código postal, diagnóstico, y datos de servicio. Ninguna información de identificación, tal como su nombre y número de seguro social, será publicada o usada en mi contra sin mi consentimiento, salvo lo permitido por ley.

Entiendo que al marcar "ESTOY DE ACUERDO Y ENTIENDO" en el cuadro siguiente, información pertinente a mi salud, incluyendo estatus de VIH e ingreso será compartida con el departamento de salud local, agentes del fisco que proveen fondos para los servicios que recibo, el Departamento de Salud Pública, División de Programas de VIH y ETS, y el Departamento de Salud Pública del Estado de California (CDPH), Sistema Regional de Información y Evaluación del SIDA (ARIES) cuando yo solicite registración para cuidado o acceso a servicios en una agencia de Programas de Ryan White. Solamente personal autorizado en cada agencia tendrá acceso a mi información cuando sea necesario. La información compartida puede incluir información sobre servicios recibidos o sobre mi tratamiento en una agencia en particular. Salud mental, servicios legales y/o abuso de sustancias será compartido según lo permitido por ley. En la mayoría de los casos, no será necesario volver a registrarse (en Casewatch Millennium®) o proveer una carta confirmando el diagnóstico de VIH cuando yo requiera servicios de una agencia que provea servicios con fondos del Programa de Ryan White o del DPH/ División de Programas de VIH y ETS.

ESTOY DE ACUERDO Y ENTIENDO

Mi registración en el Programa de Ryan White /Casewatch Millennium® no garantiza los servicios de ninguna agencia. Listas de espera o los requisitos de elegibilidad pueden excluirme de los servicios de otras agencias de Ryan White Program/Casewatch Millennium®.

Con mi firma reconozco que me han ofrecido una copia de este consentimiento, y lo he discutido con la persona indicada abajo. Entiendo que este formulario será guardado en mi expediente y mi consentimiento quedará en efecto por tres (3) años a partir de la fecha de mi firma.

Firma del Cliente o Padre/Guardián de Niño Menor

Fecha

DHSP 12-001 (Rev 6/2012)

Appendix L: Sample Notice of Privacy Practices

[This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.]

© 2003 American Medical Association
All Rights Reserved

Reproduction and use of this form by physicians and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Medical Association, Health Law Division.

[INSERT NAME OF PRACTICE]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer who is [Insert Name of Privacy Officer]

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the

physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: *We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.*

Public Health: *We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.*

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment,

payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **[Insert Name of Privacy Officer]** at (____)____-____ or **[Insert e-mail address of Privacy Officer]** for further information about the complaint process.

This notice was published and becomes effective on _____.

Appendix M People Living with HIV/AIDS Bill of Rights & Responsibilities

Please see DHSP website for link to pdf document.

Appendix N: Sample Grievance Procedures Notification Form

GRIEVANCE PROCEDURE

Any patient of THIS AGENCY may file a grievance if he/she has a concern regarding any issue involving the medical care coordination (MCC) services or any associated services provided by or through AGENCY. Any grievance regarding any concern of a patient will immediately be referred to the Project Director for resolution. The Project Director receives grievances through the following means:

Direct written communication.
Direct verbal communication.

The Project Director is _____. The Project Director may be contacted by writing or phoning at:

AGENCY NAME
123 Main Street, 4th Floor
Los Angeles, CA 90000
213-111-0000

Written and verbal grievances can be initiated by the patient, his or her significant other or any other service provider involved in the patient's care.

Unless grievances require immediate resolution, they will be discussed at the monthly Quality Management (QM) meeting. At the QM meeting the action for resolution will be determined and the Project Director will communicate the result back to the patient no later than two days after the monthly QM meeting.

If the situation requires immediate attention, the Project Director will obtain necessary information from the Case Manager to gain better insight into the situation at hand. In urgent situations which need resolution immediately, the Project Director will communicate with the patient within two days of the complaint.

If the patient is not satisfied with the solution provided by the Project Director, the patient may appeal this decision to the Administrator of THIS AGENCY, Ms./Mr. _____. This must be done in written form and may be sent by mail or by fax. The administrator of THIS AGENCY can be reached at the above address as well. The Administrator will communicate his/her response to the patient in writing within 5 working days of receipt of the written grievance.

Should the patient not be satisfied with the resolution of the grievance, he or she may contact the County of Los Angeles - Department of Public Health, Division of HIV and STD Programs Grievance Line using one of the following methods of communication:

Phone: 1-800-260-8787
Email: DHSPgrievance@ph.lacounty.gov
Web: <http://www.ph.lacounty.gov/dhsp/Grievance.htm>
Address: Attention: QM Grievance Coordinator
600 S. Commonwealth Ave., 10th Floor
Los Angeles, CA 90005

PATIENT SIGNATURE _____ DATE: _____

Patient Name:

My signature above indicates that I have received a copy of the Grievance Policy above.