Practice Standards & Administrative Guidelines for HIV Linkage to Care Specialists (LTCSs)

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

Draft Date: January 30, 2014
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INTRODUCTION

In a 2011 *Clinical Infectious Diseases* article by Edward Gardner et al, it was estimated that only 19% of HIV positive individuals living in the United States have an undetectable viral load. This is the result of individuals dropping out of the care continuum between diagnosis and maintaining treatment adherence. Figure 1 illustrates this cascade from 1.1 million individuals diagnosed with HIV to only 0.2 million individuals adherent to treatment and having an undetectable viral load.

Figure 1: The spectrum of engagement in HIV care.

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

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

- disseminated nationally by HRSA;
- incorporated locally into contracts for Ryan White and Life Care Services providers; and
- shared state-wide with all HIV medical care providers as best practices to increase client retention in care.
A key strategy of Wisconsin’s plan is the development of a new position known as a Linkage to Care Specialist (LTCS). The LTCS serves as a patient navigator or care coach, helping the client connect to HIV medical care and providing the client with the knowledge and skills necessary to be an active participant in maintaining a healthy life.

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

- **Linkage**: Client attendance at the first scheduled routine HIV medical visit with a prescribing provider after being diagnosed with HIV infection.
- **Re-linkage**: Client attendance at the first scheduled routine HIV medical with a prescribing provider post-incarceration or after being out of HIV care for more than six months.
- **Early Retention**: Client attendance of at least three HIV medical visits with a prescribing provider within the first 9 months of being linked/re-linked to care.

The LTCS works with five client populations:

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

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

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

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

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

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

GOALS AND OBJECTIVES

Short Term Objectives

- Client attends at least three HIV medical visits over the course of nine months.
- Client increases independence and transitions to self-management or case management.

Long Term Goals

- Increase retention in HIV medical care for newly diagnosed individuals living with HIV, individuals living with HIV who have been lost to care; and individuals living with HIV released from the Department of Corrections.
- Increase client knowledge of HIV disease and treatment.
- Improve client self-sufficiency.
- Increase the number of individuals living with HIV who are virally suppressed.
ROLE OF LINKAGE TO CARE SPECIALIST

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

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

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

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

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

**Newly Diagnosed**

Must meet all of the following criteria:

a. First diagnosed with HIV infection during the previous 90 days.

b. Has never received HIV-related medical care.

c. HIV diagnosis complicated by other presenting issues including **but not limited to**:
   i. Homelessness
   ii. Pregnancy
   iii. Recent HIV-related hospitalization
   iv. Mental health and/or AODA crisis
   v. Lack of insurance
   vi. Language or cultural barriers
   vii. Other perceived barriers identified by the referral source

**New to Care**

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

**Group A:**

a. First diagnosed with HIV infection more than 90 days ago.

b. Has never received HIV-related medical care.

**Group B:**

a. First diagnosed with HIV infection more than 90 days ago.

b. Has received HIV medical care previously with a pediatric HIV medical provider.

c. Transitioning to adult care from Primary Care Support Network

**Out of Care**

Must meet all of the following criteria:

a. First diagnosed with HIV infection more than 90 days ago.

b. Has received HIV medical care previously.

c. Has not attended medical appointment with HIV medical provider in the previous 6 months.

d. Does not have clinical treatment plan dictating only annual HIV medical appointment.

**Post-Incarceration**

Must meet all of the following criteria:

a. Previously diagnosed with HIV infection.

b. Incarcerated with scheduled release date OR released from DOC without notice.

c. Residing in eligible Linkage to Care service area upon release.
At-Risk

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

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

Referrals from Partner Services

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

Figure 2

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

If LTCS loses contact with client any time during the process outlined in Figure 2, refer to Figure 6 for instructions on how to proceed.
Referrals from Counseling, Testing and Referral (CTR) Sites

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

Figure 3

CTR offers referral to LTCS for eligible clients

- Client accepts referral and signs release of information allowing contact with LTCS
  - CTR contacts LTCS
    - LTCS contacts client within 48 hours
      - LTCS meets face-to-face with client within one week and formally offers services
        - Client enrolls in LTC and signs service agreement
          - LTCS informs CTR that client accepted LTC services within 48 hours
            - LTCS facilitates referral to PS if needed and informs CTR within 48 hours of client contact with PS *
              - LTCS informs CTR when client attends first appointment within 48 hours of attendance
        - Client declines LTC services
          - LTCS informs CTR that client declined LTC services within 48 hours
            - CTR continues efforts to link client to medical care
            - LTCS informs CTR when client attends first appointment within 48 hours of attendance

- Client declines referral
  - CTR continues efforts to link client to medical care

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

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

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

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

Figure 4

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

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

HIV positive inmates in the Wisconsin Department of Corrections (DOC) have their care coordinated and provided through the University of Wisconsin Hospital and Clinics. Part of the care coordination involves the UW Inmate Social Worker (UW SW) who is responsible for coordinating the client’s immediate medical need upon release from DOC. This includes scheduling an initial medical appointment, obtaining two weeks of prescription medications, and enrolling the client in the AIDS Drug Assistance Program. As the UW SW cannot work with the client after the release from DOC, the LTCS will assist with ensuring the client attends the initial appointment and then assists the client with continued engagement in HIV medical care. Figure 5 illustrates how referral and communication should be coordinated between UW SW and a LTCS.

Figure 5

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

If LTCS loses contact with client any time during the process outlined in Figure 5, refer to Figure 6 for instructions on how to proceed.
Follow-up with clients who have lost contact with LTCS

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

Figure 6

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

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

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

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

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

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

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

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

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

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<tr>
<th>Standard</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Throughout the provision of LTC services, the LTCS ensures collaboration and coordination with the LTC referral source, the client’s HIV care team and the post LTC discharge case manager.</td>
<td>1. Contact with the LTC Referral Source:</td>
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<td>The LTCS informs the LTC referral source within 48 hours of the following events:</td>
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<tr>
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<td>- Client accepts and enrolls in LTC services</td>
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<td>- Client declines LTCS service</td>
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<td>- Client attends first HIV medical appointment</td>
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<td>- Client has contact with PS (report only if referral source was CTR)</td>
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<td>- LTCS unable to establish contact with client</td>
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2. Contact with the HIV Care Team:

The LTCS maintains regular communication with the client’s HIV Care Team throughout the provision of LTC services.

Communication may occur via phone, email or face-to-face case conferencing.

- The LTCS explains their role to members of the HIV care team.

- The LTCS ensures that efforts are coordinated between members of the care team to reduce duplication of services.

3. Contact with the Post LTC Discharge Case Manager:

If the client’s goal is to transition to case management after discharge from LTC services, the LTCS must facilitate a minimum of two case conferences before discharge. One case conference must be face-to-face with LTCS, client and case manager present.

- The LTCS communicates regularly with the case manager between case conferences to further prepare for transition, implement the LTC service plan, and avoid duplication of services.
COMMUNICATION AND OUTREACH WITH CLIENTS

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

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<tr>
<td>The LTCS identifies various methods of contacting the client and maintains regular contact with clients throughout the provision of services. If the LTCS loses contact with either a client who has been referred to LTC or a client who has enrolled in LTC, the LTCS makes a reasonable attempt to contact the client before ceasing work with the client.</td>
<td>• If unable to reach a client referred to LTC services, the LTCS makes a reasonable attempt to contact the client before informing LTC referral source that the referral has been closed. A reasonable attempt to contact clients who have been referred to LTC services but not formally enrolled must include 10 contact attempts over the course of 45 days. • These attempts may all be made directly to the client. • Varied contact methods to reach the client should be used if this information is available to the LTCS. LTC referrals to clients who are unresponsive to these attempts after 45 days will be closed by the LTCS. • Once a client enrolls in LTC services, LTCS utilizes the LTC Client Locator Form (Appendix D) at intake to discuss and document: • Expectations for client and LTCS communication • Client contact information • Emergency contact • Contact information for friends/family • Contact information for service providers • Addresses where LTCS can mail letters or make unannounced visits • The LTCS updates the LTC Client Locator and corresponding releases of information throughout the provision of LTC services.</td>
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</table>
• If unable to reach a client enrolled in LTC services, the LTCS makes a reasonable attempt to contact the client before discharging them from LTC services.

A reasonable attempt to contact clients who have formally enrolled in LTC services must include 20 contact attempts over the course of 45 days.

• These contact attempts must include both attempts to contact the client directly and attempts to contact any appropriate collateral contacts.

• Documentation of attempts must show that a variety of contact methods were used including: phone calls, text messages, letters, emails, and/or unannounced visits.

• Contact attempt must result in client engagement in services in order for 45 day period of “no contact” to restart.

Clients who have been unresponsive to these attempts after 45 days will be discharged from LTC services.

• The LTCS has frequent face-to-face contact with the client in locations that are most convenient for the client.

At least one visit must occur in the client’s home or other community-based setting if the client consents.

Face-to-face contact between LTCS and client occurs at:
• intake,
• assessment,
• service plan development,
• throughout service plan implementation,
• transition plan development, and
• transition plan finalization and discharge.
**INTAKE**

Brief intake occurs during an initial meeting with the client. During intake the LTCS explains the scope of LTC services and expectations for client participation in the program. The LTCS gathers information on the client’s immediate barriers to care and determines whether the client is appropriate for LTC services. The client signs an agency-specific service agreement to indicate enrollment in LTC services. If the LTCS or client does not identify any barriers to engagement in HIV medical care, the LTCS facilitates referral to case management services.

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| Key information is documented to determine the client’s main barriers to HIV medical care and whether the client is appropriate for LTC services. | 1. Brief Intake documentation includes:  
   A. State Intake Form (Appendix A)  
      • Client name  
      • Agency specific client ID  
      • Date of birth  
      • Gender  
      • Client type  
      • Referral source  
   B. Linkage to Care Client Locator Form (Appendix C)  
      • Client contact information  
      • Emergency contact  
      • Contact information for friends/family  
      • Contact information for service providers  
      • Addresses where LTCS can mail letters or make unannounced visits  
   C. Releases of Information  
      • Agency specific  
      • Signed by client for all listed contacts  
   D. Service Agreement  
      • Agency specific |

**Time Requirement:**  
Completed within 14 days of service agreement completion.  

2. Information collected on the State Intake Form, LTC Client Locator Form and Releases of Information is documented in the client’s chart.  

3. Copies of the State Intake Form are sent to the AIDS/HIV Program for evaluation purposes.  

4. If client is deemed inappropriate for LTC service, the rationale is documented in the client chart and countersigned by LTCS supervisor.  
   
   LTCS facilitates immediate referral to case management services.
**ASSESSMENT**

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

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<th><strong>Standard</strong></th>
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| An assessment describes in detail the client’s medical and non-medical conditions and needs that may prevent or have prevented linkage and retention to HIV medical care. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access; and services not adequately coordinated. The assessment identifies the client’s resources and strengths, including family and other supports which can be utilized during service planning. | 1. Assessment documentation includes:  
A. Case Management Comprehensive Assessment (Appendix D)  
- LTCS are only required to complete shaded areas of the Assessment as outlined in Appendix D  
  |  
  |  
  | Shaded areas include information related to:  
**Core Services**  
- HIV disease progression  
- Sexually transmitted diseases  
- Other medical conditions  
- OB/GYN, including current pregnancy status  
- Medications and adherence  
- Allergies to medications  
- Alcohol/drug use/smoking history and current status  
- Mental health  
- Current health care providers; engagement in and barriers to care  
**Support Services**  
- Financial resources and entitlements  
- Transportation  
- Support systems  
- Parenting needs  
- Partner notification needs (PS)  
- HIV disclosure status/issues  
- Domestic violence  
- Legal needs  
- Knowledge, attitudes, and beliefs about HIV disease; current risk behaviors; and prevention of transmission  
- Employment/education  
**Additional Information**  
- HIV verification  
- Copy of photo identification (driver’s license, |
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<th>passport, etc.) if client has one</th>
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<tr>
<td>• Copy of Insurance card</td>
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<td>• Proof of income and residency</td>
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<td>• Other agencies serving client</td>
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<td>• Name of person completing the assessment and date of completion</td>
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2. The LTCS has primary responsibility for completing the assessment and meets face-to-face with the client to complete the assessment process.

3. Information collected on the Case Management Comprehensive Assessment is documented in the client’s chart.
SERVICE PLAN DEVELOPMENT

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

The Service Plan serves additional functions, including:
- focusing client and LTCS on priorities,
- assisting clients in negotiating service delivery systems,
- serving as a tool to evaluate accomplishments and barriers; and
- determining timeline and goal for transition to either case management of self-management following LTC discharge.

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

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<thead>
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<tbody>
<tr>
<td>Barriers to engagement in medical care identified by the client and/or LTCS during assessment are prioritized and translated into a service plan which defines specific action steps to address barriers.</td>
<td>1. Service Plan documentation includes:</td>
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<tr>
<td></td>
<td>A. Linkage to Care Service Plan (Appendix E)</td>
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<td></td>
<td>• Transition goal</td>
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<tr>
<td></td>
<td>• Barriers to engaging in HIV medical care</td>
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<td></td>
<td>• Action steps to address barriers</td>
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<tr>
<td></td>
<td>• Individual responsible for action steps</td>
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<td></td>
<td>• Action step start date</td>
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<td></td>
<td>• Action step end date</td>
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<td></td>
<td>• Status of action step at end date</td>
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<td></td>
<td>• Client, LTCS, and LTCS supervisor signatures signifying agreement and approval documented</td>
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<tr>
<td><strong>Time Requirement:</strong> Completed within 14 days of service agreement completion.</td>
<td>2. The LTCS has primary responsibility for the development of the service plan.</td>
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<td>3. Information collected on the LTC Service Plan must be documented in the client’s chart.</td>
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SERVICE PLAN IMPLEMENTATION

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
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</table>
| Provision of the LTC services outlined in the LTC Service Plan proceeds immediately after its development. Specific activities completed in the implementation phase will vary based on the unique barriers identified by each client. Core activities for effective implementation of the service plan include scheduling and preparing the client for HIV medical appointments, attending HIV medical appointments with the client, completion of the LTC Barriers Survey and coordinating efforts with the client’s care team. | 1. Core Service Plan Implementation includes:  
A. Scheduling HIV Medical Appointments  
   - LTCS assists the client in scheduling the first and second HIV medical appointments while explaining and modeling the process to the client.  
   - The client independently schedules third and subsequent appointments.  
B. Preparing the Client for HIV Medical Appointments  
   - LTCS discusses what the client can expect during the visit.  
   - LTCS assists client in preparing a list of questions they want to ask the provider.  
   - LTCS encourages the client to fully participate in the medical appointment.  
   - LTCS confirms plans for transportation and meeting with the client.  
   - LTCS contacts the client before their appointment to remind the client of appointment date and time.  
   - LTCS works with the client to develop a sustainable transportation plan for future appointments.  
C. Attending HIV Medical Appointments  
   - With the client’s consent, the LTCS attends the first medical appointment with the |
client.

- LTCS attends the second and third medical appointments if the client requests.

- At the appointment, the LTCS acts as a support and advocate for the client and leaves the exam room when requested to do so by the client or medical provider.

D. Completion of the LTC Barriers Survey (Appendix B)

- The client must complete the LTC Barriers Survey any time after they have attended their first medical appointment while enrolled in LTC services.

- The LTCS also needs to complete the LTC Barriers Survey on behalf of each client.

E. Coordination with the Care Team

- LTCS is responsible for introducing themselves to the care team and explaining their role.

- LTCS maintains regular ongoing contact with appropriate members of the client’s care team.

2. The LTCS must document the status (attended, canceled, missed) of all HIV medical appointments in the client’s chart.

3. Copies of the LTC Barrier Survey completed by the client and the LTCS must be attached and sent to the AIDS/HIV Program for evaluation purposes.
**SERVICE PLAN REVIEW**

LTC service plans are updated as action steps are completed or as the client’s life circumstances change. Due to the time-limited nature of LTC services, informal service plan reviews occur regularly between the LTCS and client. Formal reviews between the LTCS and LTCS supervisor occur at regularly scheduled intervals.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service plans are reviewed and updated regularly both with the client and LTCS supervisor.</td>
<td>1. The service plan is reviewed regularly with the client to check the progress of actions steps.</td>
</tr>
<tr>
<td><strong>Time Requirement:</strong> Update status at each action step end date.</td>
<td>2. The LTCS updates and documents the status of an action step at each estimated end date listed on the service plan.</td>
</tr>
<tr>
<td>Formal review with LTCS supervisor at 1 and 6 months after LTC enrollment.</td>
<td>3. Formal review of the service plan between LTCS and LTCS supervisor occurs:</td>
</tr>
<tr>
<td></td>
<td>• within the first month of client’s engagement in LTCS services</td>
</tr>
<tr>
<td></td>
<td>• after client has been engaged in LTC services for six months</td>
</tr>
</tbody>
</table>

*Draft*
TRANSITION PLAN DEVELOPMENT

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to self-management or case management is discussed throughout the provision of LTC services.</td>
<td>1. Transition Plan (Appendix G) documentation includes:</td>
</tr>
<tr>
<td>Transition plans are created for each client prior to discharge.</td>
<td>• Date of transition</td>
</tr>
<tr>
<td></td>
<td>• Type of transition (self-management, brief services, non-medical case management, medical case management)</td>
</tr>
<tr>
<td></td>
<td>• Summary of issues resolved during enrollment in LTC</td>
</tr>
<tr>
<td></td>
<td>• Summary of unresolved issues requiring action</td>
</tr>
<tr>
<td></td>
<td>• Individual responsible for addressing unresolved issue (client, case manager)</td>
</tr>
<tr>
<td></td>
<td>• Signature of client, LTCS and new case manager (if applicable) indicating approval</td>
</tr>
<tr>
<td></td>
<td>2. If the client’s goal is to transition to case management after discharge from LTC services, the LTCS must facilitate a minimum of two case conferences before discharge. One case conference must be face-to-face with LTCS, client and case manager present.</td>
</tr>
<tr>
<td></td>
<td>During the final case conference:</td>
</tr>
<tr>
<td></td>
<td>• LTCS, client and case manager sign off on the final transition plan. The LTCS supervisor also signs off on transition plan but does not need to be present at the case conference.</td>
</tr>
<tr>
<td></td>
<td>4. Information collected on the transition plan is documented in the client’s chart.</td>
</tr>
</tbody>
</table>
DISCHARGE

The LTCS works with the client for a maximum of 9 months. In that time it is expected that the client attends at least three HIV medical visits.

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

Reasons for discharge other than program completion include:

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon completion of active LTC services and LTC Transition Plan, a client is discharged and transitioned to self-management or case management.</td>
<td>1. Discharge documentation includes:</td>
</tr>
<tr>
<td></td>
<td>A. State Discharge Form (Appendix H)</td>
</tr>
<tr>
<td></td>
<td>• Agency specific client ID</td>
</tr>
<tr>
<td></td>
<td>• Reason for discharge</td>
</tr>
<tr>
<td></td>
<td>• Discharge service level</td>
</tr>
<tr>
<td></td>
<td>B. Completed Transition Plan</td>
</tr>
<tr>
<td></td>
<td>• Reviewed and signed by client, LTCS, case manager (if applicable) and LTCS supervisor</td>
</tr>
<tr>
<td></td>
<td>2. If unable to reach a client enrolled in LTC services, the LTCS makes a reasonable attempt to contact the client before discharging them from LTC services.</td>
</tr>
<tr>
<td></td>
<td>A reasonable attempt to contact clients who have formally enrolled in LTC services must include 20 contact attempts over the course of 45 days.</td>
</tr>
<tr>
<td></td>
<td>• These contact attempts must include both attempts to contact the client directly and attempts to contact any appropriate collateral contacts.</td>
</tr>
<tr>
<td></td>
<td>• Documentation of attempts must show that a variety of contact methods were used including; phone calls, text messages, letters, emails, and/or unannounced visits.</td>
</tr>
<tr>
<td></td>
<td>• Contact attempt must result in client engagement in services in order for 45 day period of “no contact” to restart.</td>
</tr>
<tr>
<td></td>
<td>Clients who are unresponsive to these attempts after 45</td>
</tr>
</tbody>
</table>

Time Requirement:
Client enrolled in LTC services for maximum of 9 months. Must attend at least 3 HIV medical visits during this time.

Follow-up with case manager or self-managed clients 3 months and 6 months post LTC discharge to assess engagement in HIV medical care.

Clients who are unresponsive to these attempts after 45
days will be discharged from LTC services.

3. All clients discharged from LTC services receive a discharge letter explaining reason for discharge.

   A. Letter to clients who have completed LTC services include:
   - name and contact information for case manager (if applicable), and
   - a copy of LTC Transition Plan.

   B. Letter to clients who have not completed LTC services **must be certified** and include:
   - contact information for HIV case management and clinical services
   - notification that the client may reengage in LTC services if the client contacts the LTCS within two weeks of date of discharge letter.

4. In the event of client death, referral information about grief counseling or other support services is shared with family and/or significant others.

5. The discharge letter, State Discharge Form and Finalized Transition Plan is documented in the client’s chart.

6. A copy of the State Discharge Form is sent to the AIDS/HIV Program.

**LTCS Follow-Up Post Discharge**

1. For clients who have transitioned to case management the LTCS must;
   - contact the assigned case manager 3 months and 6 months post LTC discharge to discuss the client’s current level of engagement in HIV medical care.
   - readmit the client to LTC services if case manager informs LTCS that client has had repeated episodes of non-adherence to treatment plan.

2. For clients who have transitioned to self-management the LTCS must;
   - contact the discharged client 3 months and 6 months post LTC discharge to assess the client’s current level of engagement in HIV medical care.
   - readmit the client to LTC services if the client
reports repeated episodes of non-adherence to treatment plan.

- refer the client to case management services if they require some assistance, but not intensive LTC services.

**Readmission**

1. Clients who have been previously discharged from LTC services may be readmitted if they have shown repeated episodes of non-adherence to their treatment plan since discharge and are referred by an LTC referral source.

2. Once re-enrolled in LTC services the LTCS:
   - completes a new State Intake Form
   - ensures that the client completes a new LTC Barrier Survey
   - completes Assessment Form if more than 6 months have elapsed since last enrollment in LTC Services
   - updates the LTC Service Plan
   - updates the Client Locator Form
CONFIDENTIALITY STANDARDS

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

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

PROCEDURES

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

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

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

B. For electronic record maintenance.

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

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

C. For paper record maintenance

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

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

D. Transport of records from secure office or location

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

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

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

A. Record keeping
The following information is required to be kept in client charts for the purposes of reporting and auditing:
- Demographic information
- Client Locater Form - Appendix C
- Releases of Information
- State Intake Form - Appendix A (copy sent to AIDS/HIV Program)
- LTC Barrier Survey completed by client and LTCS- Appendix B (copies sent to AIDS/HIV Program)
- Comprehensive Case Management Assessment- Appendix E
- LTC Service Plan- Appendix E
- Progress notes
- Daily Encounter Form- Appendix F (copies sent to AIDS/HIV Program)
- Status of all HIV medical appointments (attended, canceled, missed)
- Transition Plan- Appendix G
- State Discharge Form- Appendix H (copy sent to AIDS/HIV Program)

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

B. Progress notes
The Linkage to Care Specialist is required to write a progress note in the client’s chart each time an encounter occurs with or related to the client, including but not limited to:
- Each incident of client contact (in-person meeting, phone, e-mail, etc.)
- Each collateral contact
- Service distribution to the client
- Receipt of any paper work or information from consumer or third party

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

C. Daily Encounter Form
In addition to progress notes, the LTCS is also required to complete Daily Encounter Forms for each client. This is required by the SPNS ETAC for evaluation purposes.
The daily encounter form tracks the duration (face-to-face, telephone) and quantity (email, text messages, letters) of work spent with or on behalf of the client in the following areas:

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

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

An average LTCS caseload consists of 15 clients. This number does not include corrections clients who have not yet been released and clients that are yet to be located or have not yet signed a service agreement.

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

At a minimum, supervisors meet with the LTCS:

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

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

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

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

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

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