HIV Data to Care Outreach Protocol for Partner Services Providers

Division of Public Health, HIV Program

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P-02697 (3/2021)

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INTRODUCTION

Data to Care (D2C) is a new public health strategy that aims to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV Care Continuum. Operationally, the definition has been expanded to also include the use of HIV patient lists generated by HIV medical clinics, used either alone or in combination with HIV surveillance data, as a means to identify and re-engage out-of-care individuals. Although Wisconsin's Data to Care strategy follows the aforementioned methodology, it excludes the use of data to identify high-risk **negative** individuals for HIV and STI testing and referral to Pre-Exposure Prophylaxis (PrEP).

The goals of a *Data to Care* program are to:

1. Increase the number of HIV-diagnosed individuals who are engaged in HIV care.
2. Increase the number of HIV-diagnosed individuals with an undetectable viral load.
3. Prevent HIV transmission.

This protocol covers the flow of information from generating lists of out-of-care clients using HIV surveillance data, through prioritization, internal review, re-engagement, tracking and evaluation.

OBJECTIVES OF THE DATA TO CARE INITIATIVE

Utilizing HIV surveillance data, the Data to Care initiative aims to identify people living with HIV (PLWH) who are suspected of being out of HIV medical care, and utilize local health department HIV Partner Services (PS) staff to locate, interview, and offer assistance to relink these individuals back to HIV medical care. This may also include traditional aspects of Partner Services, if applicable, such as eliciting and testing partners.

PROTOCOL PURPOSE

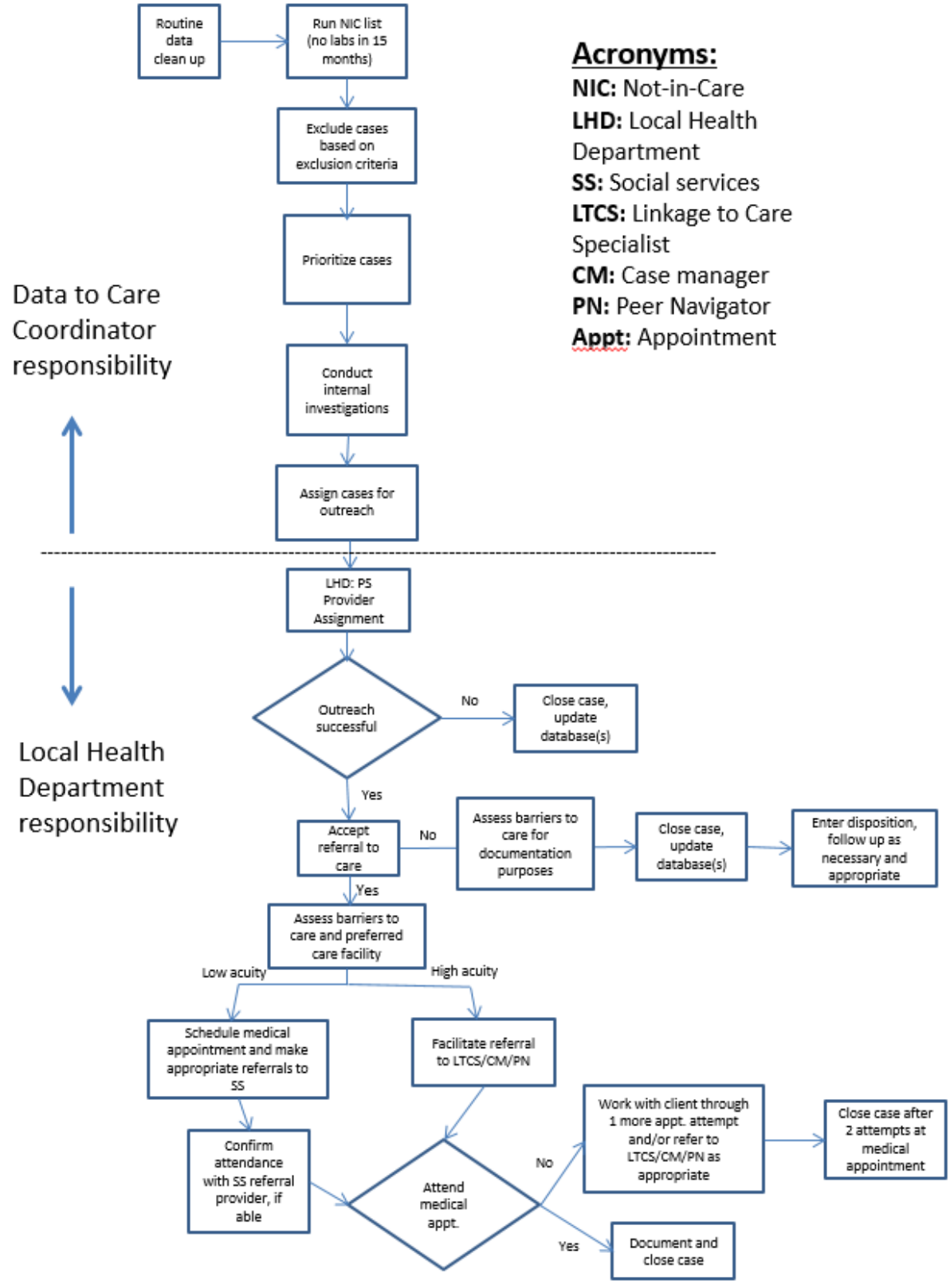
The purpose of this document is to delineate steps to locate PLWH who are presumed to be out of care (OOC), and re-engage them in HIV medical care. Being out of care is defined as having no evidence of HIV medical care per the statewide HIV surveillance system over a defined 15-month period.

Local health department (LHD) staff trained in disease investigation and partner notification, Disease Intervention Specialists (DIS), will be tasked with conducting Data to Care activities. For the purpose of this document, the terms DIS and PS Provider will be used synonymously. As explained later, Data to Care can be conducted by a Linkage to Care Specialist (LTCS). Data to Care activities and data collection conducted by LTCS are covered in the LTCS protocol.

Previously known HIV positive persons presumed to be out of care will be interviewed and offered comprehensive partner services, including: linkage to medical care or LTCS, referrals for needed supportive services, risk reduction counseling, and safer sex supplies. PS staff will interview OOC clients to elicit partners for the purpose of partner notification and to offer all named and traceable partners immediate access to rapid HIV testing or make an active referral for HIV testing services, and if applicable, link them to medical care.

The general flow of the HIV Data to Care program from identification to linkage to care is shown in **Figure 1**.

Figure 1. Data to Care Workflow



CASE IDENTIFICATION AND ASSIGNMENT

A. WISCONSIN HIV PROGRAM CASE SELECTION

The Data to Care Coordinator uses the Enhanced HIV/AIDS Reporting System (eHARS) and other available data systems to determine whether individuals are eligible for Data to Care activities, using both of the following criteria:

- No evidence of CD4 T-cell count, viral load test result, or HIV-1 genotype in eHARS during the 15-month evaluation period, and
- Presumably living in Wisconsin or requires outreach to determine current state of residence.

The resulting list is further prioritized to include only those individuals who were diagnosed or who received HIV care in Wisconsin during the past five years.

Current client residence is determined using a combination of eHARS, Accurint, the AIDS Drug Assistance Program (ADAP) database, Partner Services Web (PSWeb), the Wisconsin Electronic Disease Surveillance System (WEDSS), the Wisconsin Court System Circuit Court Access, the Wisconsin Department of Corrections database, the Wisconsin Sex Offender Registry, and the Victim Information and Notification Everyday database, or VINELink.

B. WEDSS CASE ASSIGNMENT

Eligible cases will be entered and assigned to PS staff by the Data to Care Coordinator using WEDSS. Out-of-care (OOC) individuals will be assigned to the PS jurisdiction of their current residence using the jurisdiction drop down box under the “Investigation” tab of the disease incident. The PS provider responsible for outreach will be selected under the investigator drop down box which is also under the “Investigation” tab. At this time, the “Process Status” will be labeled “New” to identify a new Data to Care case. The information described below will also be added to assist with investigation and outreach efforts.

Using the existing mechanism within WEDSS, the LHD PS supervisor can assign and triage Data to Care cases to specific DIS for investigation and outreach under the “Investigator” drop-down in the “Investigation” tab in WEDSS. Another way they can do this is to assign the case while in Jurisdiction Review by clicking “Assign” under the “Investigator” column.

CURRENT ADDRESS INFORMATION

Current address, phone number, and demographic information will be located in the "Patient" tab. The current address and phone numbers will be added to the appropriate fields, and the data source and dates of residence (if from Accurint) will be added to the comments box. To view multiple possible addresses for the client, click the icon next to the zip code field in the "Patient" tab.

LAST MEDICAL CARE

The client's last reported CD4 and viral load test dates, testing provider, and results will be located in the "HIV Clinical" tab, and will also be available for viewing in the filing cabinet located towards the top right corner of the disease incident report. The client's date of last medical appointment (as determined by date of last labs) will be located under the "Case Tracking" section.

Gender Identity

Information related to the client's gender identity, such as preferred name, pronouns, and sex at birth is located in the "Gender Identity" section of the "Patient" tab. Please review this section prior to client outreach to ensure that you are using the client's preferred name and pronouns.

CASE INVESTIGATION PRIOR TO OUTREACH

As stated above, cases are investigated internally by the Data to Care Coordinator in order to find the most up-to-date locating and care status information. PS providers should not have to conduct any further case investigation prior to outreach attempts. Please contact the Data to Care Coordinator to clarify any case/client details prior to and during outreach attempts. Please review any comments from the Data to Care Coordinator pertaining to the client prior to conducting outreach. These comments would be located in the "Comments" box under the "Investigation" tab in the client record in WEDSS.

OUTREACH, RE-ENGAGEMENT, AND LINKAGE

A. INITIAL CONTACT ATTEMPTS

This section details the necessary steps for contacting the client, conducting the interview, and re-engaging the individual in HIV medical care. All contacts and contact attempts should be documented in the "Attempts to Contact" section of the "Data to Care Investigation" tab within WEDSS, including the date, mode of contact, time of attempted contact, and outcomes of contact attempt (using the comments field). As per PS protocol, DIS should attempt to contact a client three different times at three different times of the day before closing a case out as unable to locate.

If the client is successfully located and responds to contact attempts via phone, social media, or letter, the PS provider should attempt to meet the client for a face-to-face interview. Face-to-face, in-person interviews are the expected standard for Data to Care activities. PS providers should make all attempts to schedule an interview appointment in a location that allows for private conversation and that is comfortable for the client. Suggested use of the phone call is to verify the client's identity, introduce the client to the Data to Care program, and assess the client's interest in re-engagement. A face-to-face interview should be used as a discussion to assess the client's barriers to care, provide any appropriate referrals, and to attempt to link the client back into care.

In general, client outreach is the same as that described in the current PS protocol. However, having less reliable contact information, and contacting clients because they are out of care, may necessitate different modes of reaching out to the client.

- Phone Contact**:** a phone call or text message is the preferred means for initial client contact. Consistent with the standard PS protocol, multiple phone calls/texts should be attempted at different times of the day, with no more than three attempted calls/texts before a field visit is conducted. Please see suggested voicemail script in the appendix if you need guidance on leaving a voicemail.

- Letter: letters may be sent when there is no confirmed phone number or address, or the client has not responded to phone attempts. Letters will be sufficiently vague in order to protect the client's confidentiality and should not mention HIV, sexually transmitted infections (STIs), or infectious/communicable disease. The return address should be for the health department rather than a specific program. Please use the client letter template located in the appendix for sending out letters to clients. Feel free to edit as appropriate for your agency.

- Field Visit**:** In the event that initial contact attempts are unsuccessful, a field visit to the client's residence or other location may be necessary to establish contact. If the client is not home, the PS provider should leave a blank (without a return address) envelope addressed to the client, marked 'Confidential' and enclosed with a letter from the PS provider with their contact information. Again, the letter should not mention HIV, STIs, or infectious/communicable diseases. Please use the client letter template in the appendix for this as well.

- Social Media: If contacting the client through social media or apps is warranted, please contact Craig Berger at Public Health Madison & Dane County for guidance and assistance. His contact information is cberger@publichealthmdc.com and 608-243-0355. If Craig is not available for any reason, feel free to contact Sara Mader at Public Health Madison & Dane County as back-up to Craig at smader@publichealthmdc.com and 608-243-0304.

If the client does not respond to multiple contact attempts or there are is insufficient locating information, then proceed to the Documentation and Data Collection section for case closure procedures.

B. ASPECTS OF THE CLIENT INTERVIEW AND POSSIBLE OUTCOMES

Regardless of interview type (e.g., phone or in person) the following outcomes and actions are possible:

LINKAGE TO CARE

After the PS provider introduces themselves and verifies the client's identity, the Data to Care program may be introduced. The program may be described as a new program to help people living with HIV see a health care provider regularly and to link them to other services they may need, such as housing, food, medical insurance, or employment. The PS provider should ask the client about their last HIV medical care visit, including the date, provider, and whether they were satisfied with their care.

Already in Care

Clients may report being engaged in medical care, even if their last visit was more than 15 months ago. If the client's report matches what was documented in WEDSS or is more recent, document the facility, provider name, and date of last medical visit in the "Referral and Outcomes" section in WEDSS; if the client reports having an upcoming HIV medical appointment, please document the same information. Proceed to the Documentation and Data Collection section for case closure procedures. If the client has not had an appointment in the past 15 months, but reports being "in care", emphasize the importance of seeing your health care provider once per year and the attainability of reaching an undetectable viral load. Assess if they are happy with their current provider and if you can assist them in anyway.

Not in Care

If the individual reports not being engaged in HIV medical care, use motivational interviewing to identify and assess the client's concerns and reason(s) for discontinuing or not accessing care, and to assess the client's willingness to formulate a linkage to care (LTC) plan, recognizing that medical care may not be their priority. The PS provider should highlight that linkage to care can involve linkage to other services first, such as food, housing, mental health, or substance use services. If a client would like to be referred to support services, please ensure that you document what type of support service you made a referral for and to where the referral was made. Be sure to provide the client with information on and assistance with enrolling in the AIDS Drug Assistance Program (ADAP) or the Insurance Assistance Program (IAP) through the state if they are interested. For more information on ADAP, please visit https://www.dhs.wisconsin.gov/hiv/adap.htm. For more information on the IAP, please visit https://www.dhs.wisconsin.gov/hiv/hipsp.htm. Both of these links have resources that you should feel free to print and bring along to give to clients. Please contact the Data to Care Coordinator if further questions arise regarding either of these state programs. If the client seems receptive to re-engagement in care, evaluate whether the client should be referred to a LTCS or linked directly via the PS provider.

Referral to LTCS or Medical Case Management (MCM)

Individuals should generally be referred to a LTCS for re-linkage to medical care if they:

- Have never previously had HIV medical care,

- Choose to receive their medical care at a medical clinic with on-site Linkage to Care Specialist services (UW HIV Medical Clinic, Vivent Health, Froedtert, Milwaukee Health Services, or Sixteenth Street Community Health Center), or
- Have barriers to medical care beyond what a PS provider can reasonably assist in overcoming. Please see the "What is high acuity?" document in the appendix for more clarification on which clients would most benefit from a referral to a LTCS/MCM.

If one or more of the above criteria are met, the PS provider should use their discretion and follow the referral steps documented in the Re-engagement via Linkage to Care Specialist section if it is in the best interest of the client.

Referral to Peer Navigator

Individuals who require additional assistance beyond what a DIS can feasibly provide should be referred to a Peer Navigator with the Division of Public Health Peer Navigator Program for People Living with HIV. Peer Navigators provide client-centered peer support that is designed to promote antiretroviral treatment adherence and support viral suppression. Peer Navigators provide in-need clients with HIV counseling, education, and referral services, as well as assist in navigating the health care system by assisting with scheduling and attending medical appointments with clients, among other services. Peer Navigators in this program work through Diverse and Resilient in Milwaukee.

The Peer Navigator Program identifies their key service population as:

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

The Peer Navigator Program also has specific client eligibility criteria, which is as follows:

Participants eligible for the program must meet **all** of the following criteria:

1. Reside in Milwaukee County

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

And, must meet **one** of the following criteria:

1. At risk of falling out of care (e.g., experiencing homelessness, loss of health insurance)
2. Not linked to care
3. A repeated history of falling out of care
4. A repeated history of not adhering to HIV treatment
5. Not virally suppressed

Clients receiving services through the Peer Navigator Program must also meet Ryan White Part B Eligibility, meaning they must meet **all** of the following:

1. HIV positive
2. Income eligibility based on the family income limit of 500% of the federal poverty level
3. Wisconsin resident
4. Insurance coverage or proof of being underinsured or uninsured

If you believe a client meets the Peer Navigator Program's eligibility criteria and is interested in being contacted by a Peer Navigator, please contact Justin Roby, the **Peer Navigator Program Manager**, **at 414-390-0444** and provide him with the client's contact information. Justin will then contact the client for an eligibility screen for the Peer Navigator Program. If eligible, a Peer Navigator will be assigned to the client and will contact the client directly to facilitate a meeting. Please be sure to follow-up and coordinate with Justin to ensure that your client was contacted by the Peer Navigator Program. After a client is referred successfully to a Peer Navigator, you can close the Data to Care case as appropriate.

Re-engagement via PS

Individuals with fewer barriers to care, or who have barriers that could be overcome via the PS provider (e.g., enrolling in insurance, identifying a new provider), should be linked directly to medical care by the PS provider. The following steps should be taken:

1. Determine where the client would like to receive care.
2. Assist the client in applying for health insurance and ADAP, if needed. Please see the appendix for the link that includes resources for ADAP and IAP.
3. Work with the client to schedule their first HIV medical appointment; document the appointment date, facility, and provider in WEDSS in the "Referral and Outcomes" section.
4. Work with the client to identify possible barriers to engaging in care, identify solutions, and facilitate necessary referrals.
5. Verify appointment attendance ***with the medical provider*** within two business days of the appointment date.
    a. If the medical provider verifies that the appointment was kept, proceed to the Documentation and Data Collection section for case closure procedures.
    b. If the medical provider indicates that the client did not attend their scheduled appointment, the PS provider should continue to engage with the client to identify barriers to appointment attendance.
    c. The PS provider should also assist the client in rescheduling their medical appointment or encourage the client to accept a referral to a LTCS. It is expected that the PS provider will offer appropriate assistance to re-link individuals to medical care one additional time before closing the case.

Self-linkage

If the client does not want assistance from the PS provider, refuses a referral to a LTCS, but states they will re-engage in care on their own, the PS provider should:

1. If appropriate, assist the client in identifying their preferred location to re-engage in care.
2. If appropriate, indicate you will follow-up with the client after engagement or in a month to see if the client has any unmet needs.

3. Proceed to the Documentation and Data Collection section for case closure.

Refuses Linkage

If the client is receptive to outreach but is not ready to re-engage in care, the PS provider should leave their contact information and state that they will check in with the client in a few months. It is at the discretion of the PS provider to assess the client's willingness to re-engage in medical care in the future, and therefore to decide whether the case should be closed or kept open for future outreach attempts. If a client states specifically that they never want to be contacted again, please make note of this in WEDSS and ensure that the Data to Care Coordinator is aware that that client wishes to not be contacted for Data to Care. ***Clients may decline linkage to care services at any time; all care and medical treatment is voluntary.***

RISK REDUCTION

Facilitate a risk reduction counseling session using various strategies. Effective delivery of prevention messages requires the PS provider to communicate general risk-reduction messages relevant to the client and client-specific prevention information to reduce STD/HIV transmission (i.e., condom use, limiting the number of partners, modifying sexual practices, etc.).

PARTNER ELICITATION

If the client is receptive to re-engagement and risk reduction counseling, interview the client to elicit potentially HIV-exposed sex- or needle-sharing partners per HIV PS protocols. Offer partner services and notification for the client's partners as applicable. If partners are named, the PS Provider is expected to conduct partner notification, testing, and linkage to care services for named persons exposed to HIV. This information can be added in the **"PS Investigation"** tab of the same D2C disease incident. Please use the following as a guide for entering partner elicitation information:

Partner Elicitation:

This section of the PS Investigation tab refers to the number and gender(s) of claimed partners. Remember, the number of claimed partners should always be greater than or equal to the number of named partners, which will be entered in the "Contacts" section.

Contacts:

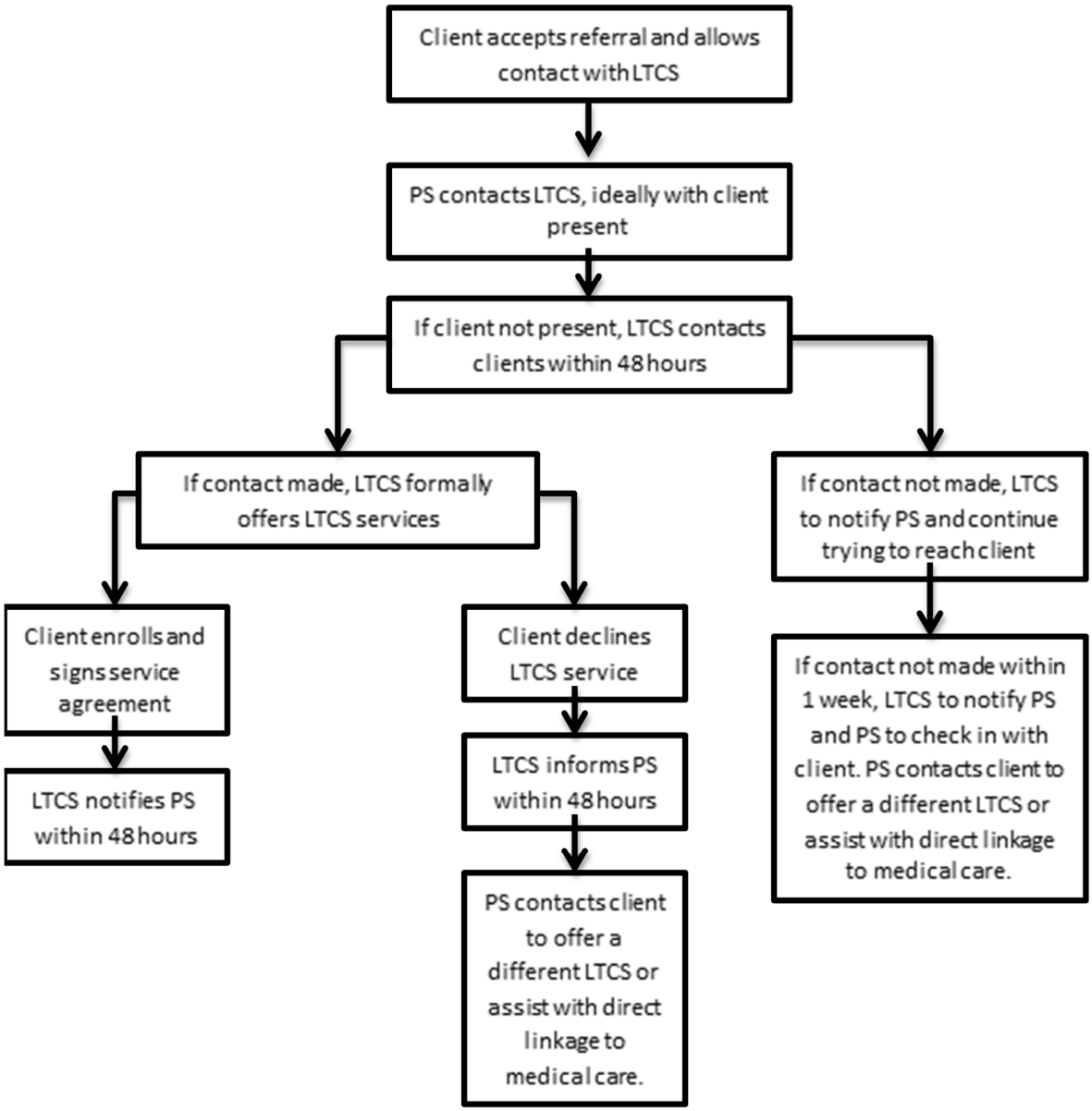
Click “Add” to add a named partner. Then, enter all information for the named partner in the pop-up box. When finished adding information, click “OK” to add the partner to the list of contacts.

Remember, the main focus of Data to Care activities is to re-engage clients into HIV medical care, but if partner elicitation occurs during interviews, document and conduct Partner Services as usual.

C. RE-ENGAGEMENT VIA LINKAGE TO CARE SPECIALIST

Many out-of-care PLWH are likely to need the more intensive re-engagement services that can be provided by a Linkage to Care Specialist. When a client is receptive to referral to a LTCS, the PS provider should work with the client to identify the client’s preferred provider for HIV medical care. Identify the LTCS or the LTCS supervisor at the medical care facility or at an agency near the client’s chosen HIV medical provider, and follow the steps in **Figure 2**.

Figure 2. PS Referral to a Linkage to Care Specialist: Timeline and Expectations



While the figure above specifies that the LTCS should notify the PS provider within 48 hours of attempted contact or of client's decision to enroll, it is the PS provider's responsibility to track the success of the referral, to reach out to the client if the referral was not successful, and to contact the LTCS if the protocol was not followed.

D. RE-ENGAGEMENT TIMEFRAME

The goal is to have the client attend an HIV medical appointment within 90 days of first being identified as out of care by HIV Surveillance. This goal and recommendation is provided by the Centers for Disease Control and Prevention (CDC).

DOCUMENTATION AND DATA COLLECTION

In order to effectively monitor and assess the success of the Data to Care initiative, proper documentation and timely entry of case outcomes into WEDSS is critical. Data to Care outcomes will be tracked using both existing and new Data to Care specific fields in WEDSS.

The specific elements to be tracked for the Data to Care initiative are described below. However, it is expected that **any** new demographic, locating, or risk information collected during the case investigation process be updated electronically in applicable and appropriate WEDSS fields before case closure.

A. CASE TRACKING

This section and the dates within it should be completed by the Data to Care Coordinator at the time of case assignment with the exception of "Date case closed to state." This date should be filled out with the date that the PS provider at the local health department closes the case and sends it back to the state HIV Program. Please keep the appointment goal date and the case due date in mind.

B. ATTEMPTS TO CONTACT

Document the attempts to contact under this section. Be sure to add a new attempt to contact for each new note/activity/attempt to contact.

C. INTERVIEW OUTCOME (UNDER "REFERRAL AND OUTCOMES" SECTION IN WEDSS)

All assigned cases **must** have an interview outcome entered prior to case closure. The Interview Outcome documents, both whether clients were able to be located, and whether clients could be interviewed. The options for interview outcomes are discussed below, including any additional information to be aware of for each outcome.

1. **Interviewed**

   The client was able to be located and a discussion about their care status took place. Individuals who are located but who refuse to discuss their care status should be documented as refusing D2C (see #4 below).

   Disposition: Interviewed

   Additional information: Ensure that a "Linkage Plan" is selected to correspond with the result of the interview in WEDSS.

2. **Already in Care**

   These individuals appeared to be out of care at the time the case was assigned to PS, but the PS provider determined the OOC person was already engaged in medical care prior to contacting the client (e.g., via discussions with the last medical provider) or through client outreach (e.g., the client reported an upcoming or very recent appointment).

   Disposition: Already in Care

   Additional information: Document the facility and provider of last medical care, including the date of the last medical visit. Document upcoming appointment information (facility, provider, date) if that is applicable.

3. **Deceased**

   If the client has been determined to be deceased through outreach attempts, please follow up with the Data to Care Coordinator to confirm vital status.

   Disposition: Deceased+

   Additional Information: Notify Data to Care Coordinator. Ensure that you have included a note regarding the source and all relevant information pertaining to the case.

4. **Declined**

   The client was located but did not respond to contact attempts, refused to speak with the PS provider, or stated they did not wish to speak to the PS provider.

   Disposition: Declined Interview

   Additional Information: The protocol specifies that the PS provider should tell the client that they will follow up with them in a few months even if they declined an interview at the present time. If the client **explicitly refuses any future follow-ups**, select the "Declined-requested no further follow up" disposition.

5. **Violence Risk**

   The client was located, but previous experience with the client was violent or threatening, the current re-engagement attempt is violent or threatening, or there is a safety concern about client's residence or suggested meeting place.

   Disposition: Violence Risk

   Additional Information: Describe the violence risk in the notes under the "Attempts to Contact" section or in the "Notes/Remarks" section under the "Investigation" tab.

6. **Unable to Locate**

   Letters, phone calls, home visits, or other activities did not yield a valid client phone number or address, or existing phone numbers or addresses could not be validated.

   Disposition: Unable to Locate

7. **Not living in Wisconsin**

   Client moved out of the state. Use the "Contact Attempts" section in the Data to Care Investigation tab in WEDSS to add notes about current residence and to indicate where the client has moved so that the surveillance database can be updated.

   Disposition: Not living in Wisconsin

Additional Information: Add as much of the current address as is known to the Address field in the "Patient" tab. To add multiple addresses please select the icon next to the "Zip" field.

8. **Other, please specify**

Use this disposition for any other reasons why the client was not interviewed (e.g., out of PS jurisdiction). Please notify the Data to Care Coordinator if a client is living in another PS jurisdiction so that they can provide timely re-assignment to the other jurisdiction.

Disposition: Other, please specify

Other Disposition: Include other interview outcome disposition in the "other" field to the right of the "Interview outcome" field.

D. CLIENT LOCATING INFORMATION

Document the address and phone number at which the client was reached in the main "Patient" tab in the client's Data to Care record.

E. REASONS NOT IN CARE (UNDER "REFERRAL AND OUTCOMES" SECTION IN WEDSS)

As part of evaluating the Data to Care program, reasons for being out of care will be associated with client outcomes. Barriers to HIV medical care must be documented in the interview notes and in the "Reason Not in Care" drop-down menu under the "Referrals and Outcomes" section. If the client is already in care and this field is irrelevant, please leave this field blank. The following are current options for this field:

- Insurance/finance related
- Philosophical/religious
- Mental health
- Substance use
- Transportation
- Homelessness/housing insecurity
- Other, specify

- If selected, please specify the main reason the client is not in care (if none of the options above) in the “other” field directly to the right of the “reason not in care” field.

F. LINKAGE PLAN AND LINKAGE OUTCOME (UNDER “REFERRAL AND OUTCOMES” SECTION IN WEDSS)

1. **Already in Care**

   For clients stating they are already engaged in HIV medical care, document the following:

   Facility: Please enter the name of the facility at which the client states they are in care. The icon next to this field is where you can search for facilities.

   Provider: Please enter the name of the health care provider with which the client is in HIV medical care.

   Date of last medical appointment: Please enter the date that the client reported last seeing their HIV-related health care provider.

   Date of next medical appointment: Please enter the date of the next medical appointment the client has scheduled with their HIV-related health care provider.

2. **Referral to LTCS**

   For clients who will be referred to an LTCS, case manager, or Peer Navigator, document the following:

   HIV case manager, LTCS, or Peer Navigator as applicable: Please enter the case manager, LTCS, or Peer Navigator name in this field as appropriate.

   Linkage plan: Accepted linkage services.

   Linkage outcomes: Please indicate whether the client accessed the linkage services with the case manager, Peer Navigator, or LTCS.

   From there, the Peer Navigator, LTCS, or case manager should complete the rest of the case documentation, granted the client accesses the referral they were given.

3. Accepted linkage services

For clients linked directly to HIV medical care by the PS provider, document the following:

Linkage outcomes: Please indicate whether the client accessed the linkage services (i.e., went to the appointment set up by PS).

Facility: Please enter the name of the facility where the client's HIV medical appointment was made.

Provider: Please enter the name of the provider that the client's HIV medical appointment was scheduled with.

Date of next medical appointment: Please enter the date of the scheduled (i.e., next) medical appointment.

4. Client plans to re-engage on their own

For clients who indicate that they will self-link to HIV medical care, document the following:

Additional Information:

Document where and when the client plans to re-engage in medical care, if that information is provided. Document any follow-up contact and linkage outcomes in the appropriate fields in WEDSS.

5. Refused Linkage

If the client is not ready to re-engage in care and refuses linkage, select "refused linkage" as the linkage plan.

6. Not Interviewed

If the client is not interviewed in any capacity (e.g., due to violence risk, being deceased, being incarcerated, having moved, or not being located) please select "not interviewed" as the linkage plan.

7. Other, please specify

G. OTHER REFERRALS

Please indicate the type of support service referrals that are made to the client and include all appropriate information (e.g., facility name, provider, date of follow-up, and referral outcome). There are several types of support service referrals in the drop-down menu. If you select "other," please specify in the text box to the right. Please include if you provided ADAP/IAP resources in this section.

H. CDC REQUIRED VARIABLES

These are the variables that are required by CDC for upload in eHARS biannually. Most of these variables will already be completed by the time a case is assigned. The PS Provider (or LTCS/CM if client worked with these individuals) should complete the following variables as accurately as possible at time of case closeout:

- Disposition of linkage or re-engagement with care intervention
    - No intervention initiated
    - Linkage/re-engagement intervention declined by client
    - Returned to care before intervention was initiated
    - Linkage/re-engagement intervention not initiated, not successfully linked to/re-engaged in care
    - Linked to/re-engaged in care, documented
    - Linked to/re-engaged in care, client self-report only
    - Linkage/re-engagement status unknown
- Date returned to, linked to, or re-engaged in care (applies only if client was returned to, linked to, or re-engaged in care).

SENDING CASES BACK TO THE STATE FOR REVIEW

When a case is closed out and ready to be sent back to the Data to Care Coordinator at the state HIV program, please use the following steps:

1) Ensure that all data and case information described above in this protocol is included (especially the CDC required variables as well as the “date closed to state” in Case Tracking).
2) Leave jurisdiction as county of residence.
3) Switch investigator to Elizabeth Schroeder.
4) Switch process status to “sent to state.”

At this point, the HIV Data to Care Coordinator will receive the case in their WEDSS queue and review.

APPENDICES

Appendix A: Sample Letter

Appendix B: Sample Voicemail Script

Appendix C: ADAP and IAP Resources

Appendix D: High Acuity

Appendix A: Sample Letter

Date:

Dear _____,

_____ County has developed a county-wide program that helps eligible residents receive supplementary health care and social services to benefit their overall health. You are one of the many in your county who have been selected to participate in this confidential and important health program. Please call or text _____ (enter number here) to learn more about this health program and how it can benefit you. **All information will be kept confidential.** When we contact you, we will need to verify your identity prior to proceeding. If there is no answer, please leave your name, number, and the best time to contact you on our secure and confidential voicemail and I will return your call.

Thank you for your time and I look forward to hearing from you.

Sincerely,

_____

Engagement Specialist

_____ County Health Department

Appendix B: Sample Voicemail Script

Voicemail message to leave if no one answers:

"Hello. This is _____ (first name only) from _____ County calling for _____. When this message is received, please return my call at _____. _____ (client name) has been selected to participate in a new health program for eligible _____ County residents to help assist in receiving supplementary health care and social services. Please have _____ (client name) contact me at _____. Again, my name is _____ (first name only) with _____ County. Thank you and have a great day!"

Appendix C: ADAP and IAP Resources

ADAP homepage link: https://www.dhs.wisconsin.gov/hiv/adap.htm

IAP homepage link: https://www.dhs.wisconsin.gov/hiv/hipsp.htm

ADAP/IAP fact sheet link (English and Spanish versions available): https://www.dhs.wisconsin.gov/library/P-42115.htm

For further questions about ADAP/IAP please call: Hanna Bruer, ADAP Coordinator, 608-267-6875, or email at hanna.breuer@dhs.wisconsin.gov.

Wisconsin AIDS Service and Community-Based Organizations that assist with ADAP Applications		
City	**Agency**	**Phone Number**
Appleton	Vivent Health	920-733-2068
Beloit	Vivent Health Beloit Area Community Health	608-364-4027 608-361-0311
Eau Claire	Vivent Health	800-750-2437
Green Bay	Vivent Health	800-675-9400
Kenosha	Vivent Health	800-924-6601
La Crosse	Vivent Health	800-947-3353
Madison	Vivent Health UW HIV Comprehensive Care Program	608-316-8600 608-263-0946
Milwaukee	Vivent Health Froedtert Infectious Disease Clinic Milwaukee Health Services Outreach Community Health Center Sixteenth Street Community Health Center Wisconsin HIV Primary Care Support Network	800-359-9272 414-805-6444 414-372-8080 414-374-2400, ext. 1109 414-672-1353 414-225-1562
Superior	Vivent Health	877-242-0282
Wausau/Schofield	Vivent Health	800-551-3311

Appendix D: High Acuity

What is "high acuity"?

If a client experiences any, or several, of the following, they would best be served by a referral to a linkage to care specialist or case manager:

- History of difficulty linking to or retaining in HIV medical care
- Require immediate intervention or intensive support and education in order to maintain treatment adherence
- Inability to navigate health care or insurance systems without intensive support
- Difficulty advocating for themselves to medical providers
- Behavioral health and/or substance abuse resulting in significant interference in their ability to remain in care and adhere to treatment
- Homelessness or housing insecurity
- Lack of public or private transportation
- Lack of support system

Please keep in mind that in order to be served by a case manager or linkage to care specialist, clients must meet the following Ryan White eligibility criteria:

1. Wisconsin resident
2. HIV positive
3. Income is less than 500% of the federal poverty level
4. Insurance coverage or proof of being underinsured or uninsured

Also, please review the information on referral to a Peer Navigator, including their eligibility criteria and key populations for service.