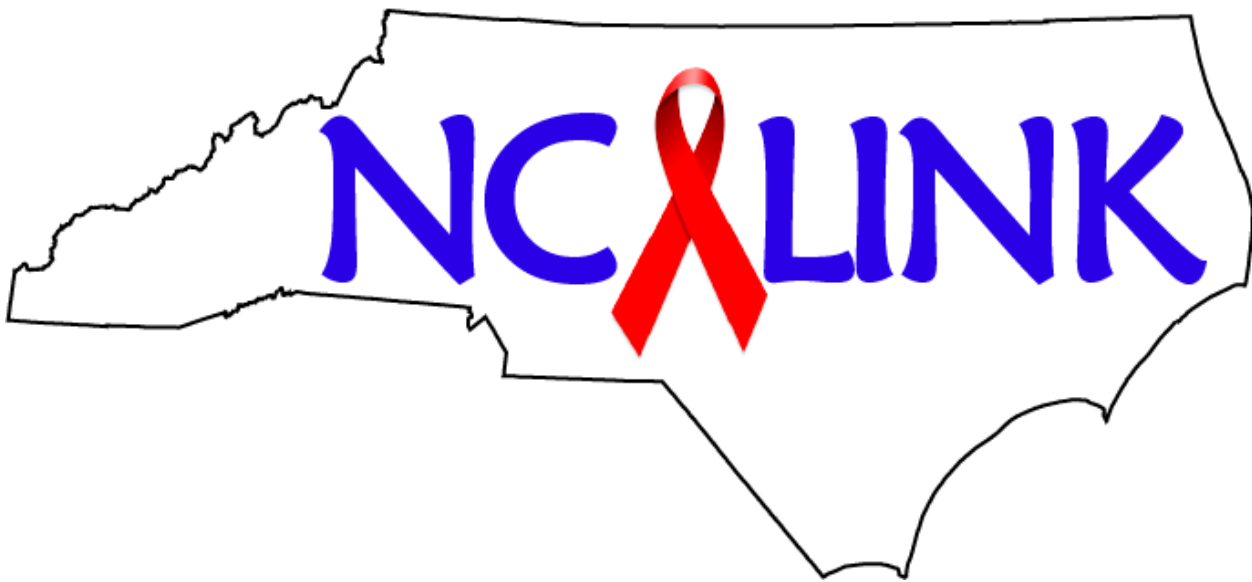


North Carolina Systems Linkage and Access to Care Initiative

NC-LINK

INTERVENTION MANUAL
INSTRUCTIONS FOR REPLICATION



*Special Thanks to the following
for their much appreciated help in creating this manual:*

NC-LINK pilot and expansion intervention sites

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All information within this manual is a product of the NC-LINK project, unless otherwise referenced.

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Glossary of Terms

ADAP—AIDS Drug Assistance Program

ARTAS—Anti-Retroviral Treatment and Access to Services

ARV—Anti-Retroviral Therapy

BC—Bridge Counselor

CAPUS—Care and Prevention in the United States

CDB—Communicable Disease Branch

CDC—Centers for Disease Control and Prevention

CW—CAREWare

DIS—Disease Intervention Specialist

HAB—HIV/AIDS Bureau

HRSA—Health Resources and Services Administration

MCM—Medical Case Management

MSM—Men who Have Sex with Men

NC DHHS—North Carolina Department of Health and Human Services

NC EDSS—North Carolina Electronic Disease Surveillance System

NHAS- National HIV/AIDS Strategy

OOC – Out of Care

ORN—Outreach Nurse

PDSA- Plan-Do-Study-Act

PLWH—Persons Living With HIV

PN—Patient Navigator

RNC—Regional Network of Care

RW—Ryan White

SBC—State Bridge Counselor

SPSBC—Special Populations State Bridge Counselor

SPNS—Special Project of National Significance

Introduction

About this Manual

In a 2011 *Clinical Infectious Diseases* article by Edward Gardner et al, it was estimated that only 19% of HIV-infected 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 treatment adherence and ultimately not reaching the gold standard of HIV viral suppression. Known as the cascade of care, the proportion of people who reach the next level of care engagement decreases between each stage of HIV diagnosis and care. This is illustrated by the 1.1 million individuals diagnosed with HIV, as compared to only 0.2 million individuals adherent to treatment and possessing an undetectable viral load.¹

The cascade of care reinforces the need to achieve the goals of the National HIV/AIDS Strategy, specifically increasing access to HIV care to optimize health outcomes for individuals living with HIV. As part of this effort to increase participation in HIV care, improve health outcomes, and ultimately reduce disease transmission, the Health Resources and Services Administration (HRSA) funded a four-year Special Projects of National Significance (SPNS) initiative to design innovative models to assist HIV-infected individuals to link to and stay engaged in HIV medical care. North Carolina was one of six states chosen to implement structural changes and new innovations as a part of the *Systems Linkage and Access to Care for Populations at High Risk of HIV Infection* Initiative. North Carolina’s project is called *NC-LINK: Systems Linkages and Access to HIV Care in North Carolina*.

The primary goal of *NC-LINK: Systems Linkages and Access to HIV Care in North Carolina* is to increase the number of people living with HIV/AIDS (PLWH) who are engaged in consistent care by creating a ‘system of linkages’ along the HIV continuum of care in North Carolina. This was accomplished through improved coordination between HIV testing and HIV care providers; creating integrated NC HIV data sources and regional data repositories; testing and linkage to care within the networks of high risk persons; improving the capacity of regional and clinic-based retention staff to retain HIV-infected individuals in care and to engage those who are lost-to-care; and creating a statewide team of bridge counselors to rapidly link newly-diagnosed HIV patients into care and reengage patients who are out of care. This project has the potential for extensive reach and powerful implications for implementation in and replication in other settings across the state, region, and even country. NC-LINK interventions address each level of the HIV Continuum of Care (see Figure 1 below) and are designed to bridge gaps so that every PLWH in NC can access quality care.

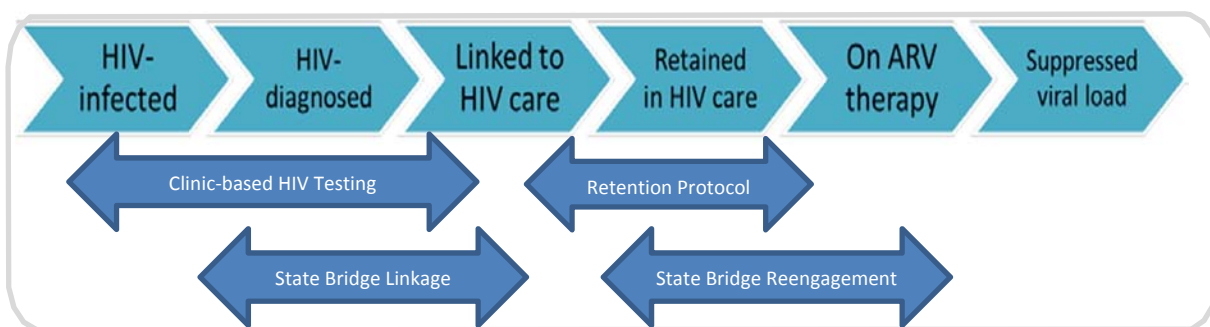


Figure 1. HIV Continuum of Care impacted by NC-LINK

This manual outlines the strategy and lessons learned for each of the 4 interventions in the NC-LINK project. The objectives of this manual are to explain the specific components of each intervention; describe the success of each intervention in linking and retaining PLWH in care; emphasize lessons learned; and disseminate information that reduces HIV incidence, increases access to care, and reduces HIV-related health disparities, in concordance with the National HIV/AIDS Strategy (NHAS).

The primary target audience for this manual includes retention and medical staff of clinics serving PLWH, public health field service unit staff members and leadership who are involved in engaging PLWH in care. The secondary audience is anyone who would like to use part or all of this system of care to increase the number of PLWH who are retained care.

HIV/AIDS in North Carolina

An estimated 35,000 people are living with HIV/AIDS in NC, including those who were unaware of their HIV status.² A total of 26,168 people PLWH had been diagnosed and reported to the North Carolina Division of Public Health (NCDPH) as of 2011.³

Of the 45 states reporting new HIV cases to the Centers for Disease Control and Prevention (CDC) in 2011, North Carolina ranked 12th, with a rate of 17.8 cases per 100,000, compared to 16.3 cases per 100,000 for the US as a whole. In the same year, there were 1,563 new HIV diagnoses, the vast majority of which were among adolescents and adults aged 13 years and older. Of those diagnoses, 26.1% were accompanied by a concurrent AIDS diagnosis, indicating that those individuals probably had HIV for five to seven years. African Americans were disproportionately represented among these new cases, with the rate of new HIV diagnoses for adult/adolescent blacks (62.8 per 100,000) being 10 times greater than the rate among whites of the same age (6.3 per 100,000).³

Similar to national trends, HIV/AIDS does not affect all sociodemographic groups equally in NC. In 2011, 70% of PLWH in NC were male. In addition, African Americans made up two-thirds of all PLWH and 26% were White, 6% were Hispanic, 1% were American Indian/Alaskan Native, and 1% were Asian/Pacific Islander. The leading mode of HIV transmission was MSM (47%), followed by heterosexual transmission (38%), injection drug use (11%), and MSM and IDU combined (3%).³

In addition to racial and gender disparities, HIV/AIDS cases are more prevalent in urban areas. In fact, 74% of PLWH lived in an urban area in NC. The Charlotte Metropolitan Statistical Area - the largest metropolitan area in NC - accounted for 22% of all cases. Furthermore, five of NC's 100 counties were home to more than 50% of all new HIV diagnoses in 2011: Mecklenburg, Wake, Guilford, Cumberland, and Forsyth.³

Why Systems Linkage?

HIV/AIDS Services in North Carolina

Care for people living with HIV/AIDS in NC is provided by a network of hospital-based clinics, academic medical centers, community-based health centers and organizations, and private infectious disease practices. Many PLWH receive care with funding through the Ryan White Program, administered by the Health Resources and Services Administration (HRSA). These services are for PLWH who do not have financial and insurance resources to otherwise obtain HIV care. In 2010, the state created ten regional networks of care (RNCs), with overlapping prevention regions, to manage Ryan White funding and services in their geographical area (See Diagram 2 below). These RNCs cover 95 of NC’s counties, with a single lead agency for each region.

The NC Division of Public Health (NC DPH) supports health education and risk reduction services to provide prevention services to people at-risk for HIV infection. These services also provide education to PLWH to improve understanding of the virus and reduce transmission. Additionally, the NC DPH coordinates partner counseling and referral services. The Field Services unit employs 28 disease intervention specialists (DIS), working out of seven regional field services offices who contact newly-diagnosed individuals to identify partners who are at-risk for infection and refer the individual to medical care.

In North Carolina, HIV testing is available at all local health departments and through many community-based organizations, to which the state provides free rapid test kits. The majority of testing in the state is done at sexually transmitted infection clinics.

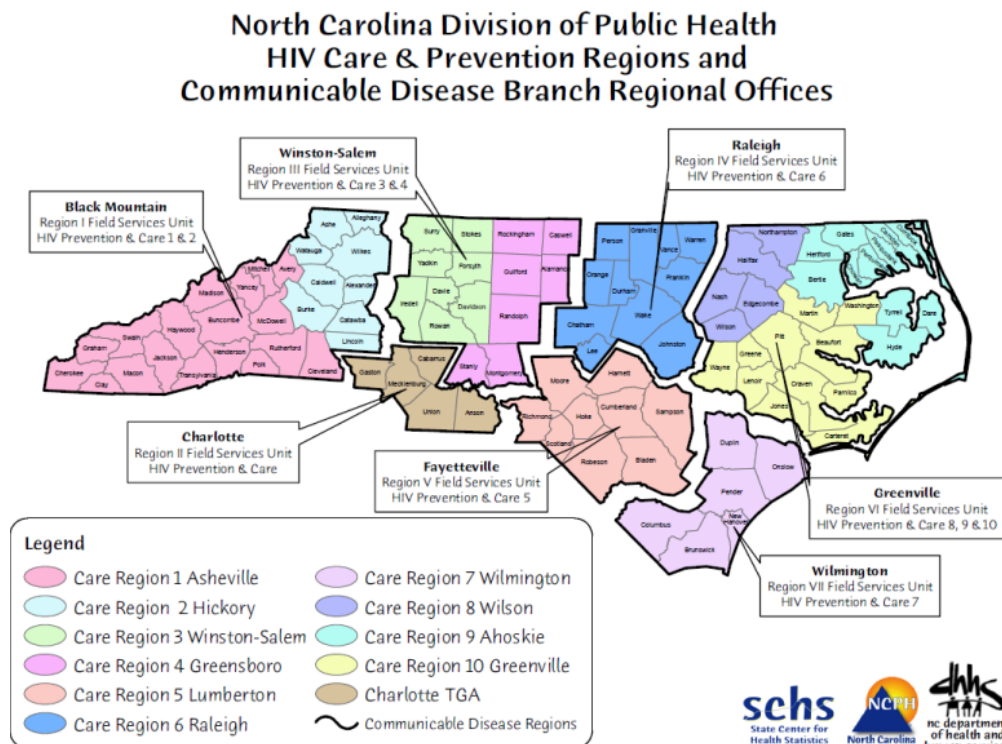


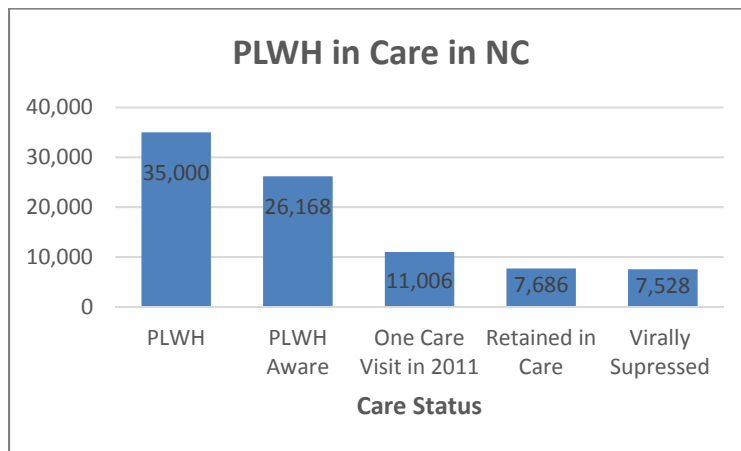
Figure 2. North Carolina HIV Prevention and Care Regions. Source: NCDPH

A State of Need

In 2011, NC-LINK was developed to address gaps in care present in NC and provide a coordinated statewide plan for improving the health outcomes for PLWH. Despite the extensive services offered in NC in 2011, communication between existing state-level programs in HIV surveillance, testing and care was often lacking coordination and communication between care providers was not statewide. Consistent with national trends, there is also a large proportion of PLWH in NC who are not engaged in consistent medical care. In addition, surveillance of medical care at the state level had not been a priority. Reporting gaps made it difficult to determine when people were receiving care.

Late testers, those who also receive a diagnosis of AIDS within 6 months of their initial HIV diagnosis, accounted for 26% of newly diagnosed individuals in 2011.³ Of the estimated 35,000 PLWH in NC, there were only 26,168 reported diagnoses,⁴ indicating that an estimated 8,832 PLWH were not aware of their HIV status. These statistics underscored the need for increased and improved testing in NC.

In 2011, only 44% (11,006) of the 26,168 diagnosed PLWH with known diagnosis accessed at least one care visit. Additionally, only 31% of diagnosed PLWH (7,686) were considered to be retained in care -- defined as at least two care visits at least three months apart and only 30% (7,528) were virally suppressed.⁴ These data are represented graphically below, based on the HIV/AIDS treatment cascade and indicated the need for linkage to and retention and reengagement in care services was probably significant despite the recognized limitations in surveillance data.



The HIV Cascade, or Continuum, of Care in North Carolina can be represented as having four significant gaps where PLWH are not accessing or being retained in care. These are: Gap 1- Individuals unaware of their HIV infection (testing); Gap 2- Newly-diagnosed individuals not entering HIV care (linkage); Gap 3- Persons engaged sporadically in HIV care (out-of-care) and Gap 4- Persons not receiving HIV care (lost-to-care).

In order to remove these disparities in accessing care, people living with HIV/AIDS (PLWH) need a coordinated multidisciplinary approach, or *systems linkage*, that promotes HIV testing, entry to, and retention in care by creating a system of linkages along the HIV Continuum of Care in North Carolina. This will be accomplished by decreasing the number of people who are HIV-infected and unaware; increasing rapid linkage into high quality HIV care for those who are newly diagnosed; improving retention in HIV care for those who are receiving sporadic care; and facilitating re-engagement of those patients who are lost to care.

To achieve the goals outlined above, four interventions were developed. These interventions are Clinic-based HIV testing, the Retention Protocol and State Bridge Counseling for Linkage and for Re-engagement.

Overview of Interventions

1. Clinic-Based HIV Testing: *for HIV-unaware Gap and Linkage to care Gap*

This initiative offers any individual (friend, family, partner) who accompanies an HIV-infected patient to a clinic appointment with the opportunity to receive free and confidential rapid HIV testing at the clinic. Staff were trained on conducting rapid testing using saliva and the OraQuick® assay. The test is offered free of charge, without patient registration, does not involve a blood draw and with results available in 30 minutes. A negative result is given by staff to the visitor along with brief individualized prevention counseling. If the test is positive, the visitor is then offered immediate entry to care through registration into the clinic for confirmatory testing.

2. State Bridge Counseling Linkage Services: *for Linkage to care Gap*

State Bridge Counselors (SBCs) work with four client populations: newly-diagnosed, new to care, out of care, and high risk clients requiring urgent care. The SBC receives referrals of newly-diagnosed clients from the NC Division of Public Health's Disease Intervention Specialists (DIS). The SBC ensures rapid linkage to care through confirming clients attend their first medical appointment (scheduled by DIS) or assisting the client in scheduling and attending the first appointment. New to care in NC clients (e.g. might have moved from another state) can be referred by a variety of sources, including DIS, medical providers or ancillary care providers. The SBC provides Linkage services to both of these populations.

3. Retention Protocol: *for Retention in care Gap*

This strategy focuses on developing the capacity of clinic or region-based bridge counselors/patient navigators and medical clinic staff, collectively referred to as "retention staff," to retain PLWH in HIV care. Retention staff run monthly CAREWare (a free scalable software provided by HRSA Ryan White-funded organizations to manage and monitor HIV clinical and supportive care) reports of HIV clients who have not attended medical appointments in the previous 6-9 months and do not have a scheduled appointment, and follow a protocol to search for and re-engage these clients. Additionally, retention staff utilize tracking and referral functionality within CAREWare to document and share their efforts at locating and retaining clients, referring clients who cannot be located to State Bridge Counselors.

4. State Bridge Counseling Re-engagement Services: *for Re-engagement Gap*

SBCs assigned to regions implementing the retention protocol intervention also receive referrals from retention staff for patients they were unable to locate and/or engage in care. The SBCs then work to locate and re-engage these patients who have been out of care for 6-9 months or longer. They use strengths-based counseling techniques to increase self-efficacy, eliminate barriers, and facilitate patient efforts to re-establish medical care. Dedicated Special Populations SBCs focus on linking pregnant women and clients who are post-incarceration to HIV care who need either the Linkage Services or the Re-engagement Services.

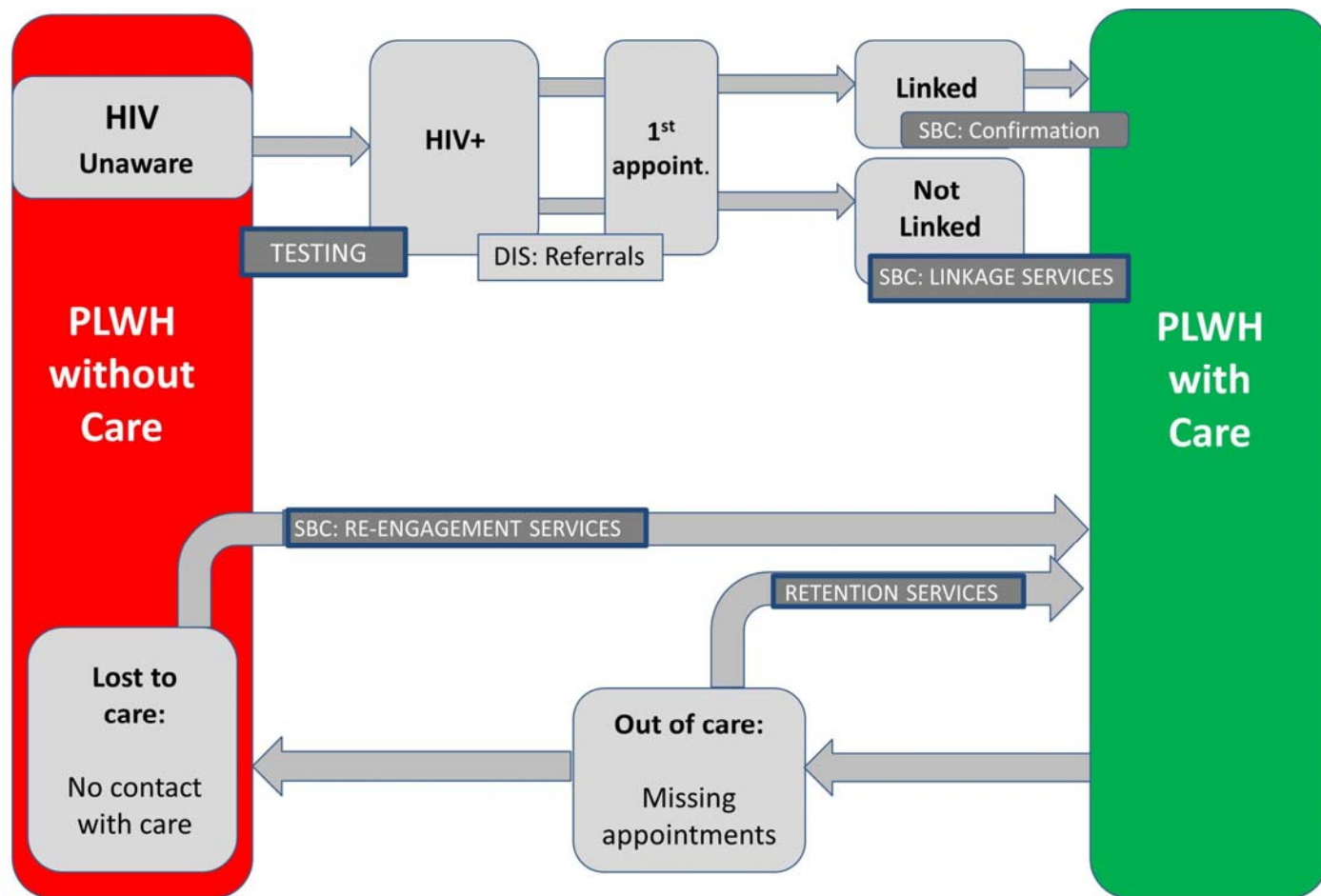


Figure 3 Circle of Care. Leftward arrows: movement of PLWH toward care; Rightward arrows: movement of PLWH out of care.

Pre-Implementation

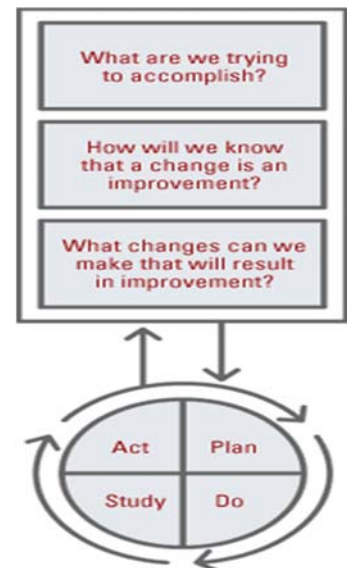
The Learning Collaborative

The first two years of NC-LINK (2012-2013) were dedicated to forming and facilitating a Learning Collaborative to design, test, and select interventions for expansion. A Learning Collaborative is formed to help facilitate rapid changes in healthcare delivery in a complex healthcare delivery setting. The NC-LINK Collaborative used a Steering Committee, Learning Sessions, and Plan-Do-Study-Act (PDSA) cycles⁵ to create common goals, develop and test proposed interventions and quickly determine the successful and necessary elements of the interventions. The Collaborative also supported the incorporation of these inventions as a permanent part of the healthcare organization’s activities and selected interventions for wider-scale dissemination within the state. A diverse group of HIV care providers, the study team, and academic institutions contributed to the Learning Collaborative.

Steering Committee: The NC-LINK Steering Committee included project leadership, representatives from the NC Communicable Disease Branch and from partnering HIV prevention and care organizations. The primary responsibility of the Steering Committee was to plan and host three Learning Sessions, provide assistance to pilot sites and track progress on the pilot interventions via PDSA data collection and feedback.

Learning Sessions: The NC-LINK study team hosted three Learning Sessions to bring members of the Collaborative together. These two-day meetings were held approximately six months apart from one another. During the first Learning Session, hosted in April 2012, implementation groups were developed and three initiatives were launched. In November 2012, at the second Learning Session, groups reported back on the success of their PDSA cycles and planned for activities to take place prior to the third Learning Session, held in April 2013. The final Learning Session focused on sharing results of the pilot interventions and planning for expansion to additional sites.

Model for Improvement & PDSA Cycles: In between the Learning Sessions, implementation groups conducted tests of interventions using the Model for Improvement. This model, depicted in the figure to the right (image source: IHI) includes three key questions: 1. What are we trying to accomplish? 2. How will we know that a change is an improvement? 3. What change can we make that will result in improvement? The PDSA model is a way of examining an intervention’s success in a systematic way that works in real-world settings. Five interventions were tested through the PDSA model: alternative HIV testing strategies, clinic-based partner HIV testing, emergency department testing, regional retention, and State Bridge Counseling linkage and retention services. At the conclusion of the Learning Collaborative, results pointed to interventions suitable for expansion and replication on a wider-scale basis. The alternative testing intervention was successfully implemented on a small scale but was not able to be expanded and it was decided to be unsuitable for replication. The emergency department testing intervention was not able to be initiated for piloting. The NC-LINK team and pilot sites had also gained expertise that would serve to assist expansion sites in implementing the selected four interventions.⁵

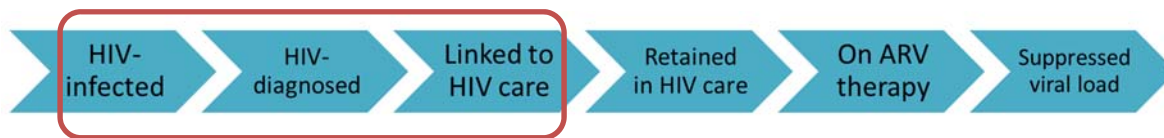


1. Clinic-Based HIV Testing Intervention

Target Population: Any adult who accompanies an HIV-infected patient to their medical visit

Target Audience for Intervention Implementation: Staff of medical clinics serving people living with HIV/AIDS

Intervention Aim & Rationale: The aim of this intervention is to identify persons with undiagnosed HIV infections and link these persons to care. By targeting individuals accompanying HIV-infected individuals to care visits, HIV testing is directed to individuals who members of the social network of PLWH and are expected to be at higher risk than members of the general population



This intervention directly addresses two gaps in the HIV Care Continuum by identifying persons with undiagnosed HIV infections and linking these persons to care. It is estimated that as many as 28% of PLWH in NC are unaware of their status. It aligns with the National HIV/AIDS Strategy objective to increase the percentage of PLWH who know their serostatus (to 90%). Since these PLWH are identified in a medical setting and immediate information regarding medical care can be provided, high rates of linkage to care occur (>90%). As an intervention at the beginning of the Care Continuum, this intervention impacts all subsequent steps including, client retention, ARV therapy, and viral suppression. Identifying and linking and retaining new patients in care and starting them earlier on therapy can have a great impact on the remaining steps of the cascade.

Overview of Services:

Individuals who accompany an HIV-infected patient to their clinic appointment are able to receive free and confidential rapid HIV testing at the clinic. The PLWH and their companions are made aware of HIV testing through discussions with medical providers and support staff in the clinic. If an individual desires HIV testing services, s/he is directed to one of the Infectious Disease support staff in the clinic (i.e. patient navigator, social worker, study coordinator, or other trained staff) for testing. Following an assessment of risks and provision of information regarding HIV testing, a rapid test (OraQuick® was used in this intervention) is performed. Negative results are provided to the individual in approximately 20 minutes by the support staff member. If a positive result occurs, a medical provider may deliver the result or discuss the result after the delivery of the result by the support staff member. This staff member will provide risk reduction counseling for a negative result or immediate entry to care through registration into the clinic for confirmatory testing for a positive result. It is important for the newly diagnosed individual to hear quickly from a medical provider that they will be able to receive care and they are expected to respond to medications enabling a normal life-expectancy.

Collaboration with the local or state health department is a critical component of this intervention. For the purposes of the pilot protocol, outlined below, the medical clinic serves as a satellite testing site of the local health department. The health department collects the initial testing data as it is funded to support testing in

the community and enables the medical clinic to provide the rapid test without establishing a client record. The service is advertised as: HIV testing with no time, no needles, no cost, and no hassle.

Key Components of Intervention:

Staff required:

Program management. The HIV Medical Director is the responsible physician and site director for the testing program. A project coordinator is responsible for the management of this program. At the sites conducting the testing during NC-LINK, quality improvement coordinators and clinic managers were selected for this role.

Testing staff. At least 3 staff members should be formally trained to do HIV counseling and testing. The NC Communicable Disease Branch (CDB), a division of the NC DPH, provided the training for HIV testing and counseling to clinic staff at no cost and state health departments are expected to be a resource to provide this training. Counseling and testing activities may be performed by separate individuals. After training, nurses, patient navigators, social workers, or other support staff may provide pre-test interviews, and counseling to the clients. Subsequently, trained medical staff perform the rapid test as well as deliver test results and post-test counseling. However, sites may choose to train support staff to perform the testing and involve medical providers only if a result is positive. At one NC-LINK site, testing staff includes 5 patient navigators, a social worker, a nurse and a clinic manager. A second NC-LINK site has one phlebotomist who performs the rapid test and 6 nurses who help with pre/post-test counseling.

Protocol:

Individuals who accompany an HIV-infected patient to their clinic appointment will have the opportunity to receive free and confidential rapid HIV testing at the clinic. Testing will only be available to individuals who come in with a patient; walk in testing is not required as part of this protocol, but may be offered at the clinic's discretion.

These patients and accompanying individuals will be made aware of HIV testing through marketing materials (e.g. flyers) in the exam rooms and discussions with medical providers and support staff in the clinic.

If an individual desires HIV testing services, s/he will be directed to one of the counseling staff in the clinic (i.e. patient navigator, social worker, study coordinator, and other trained staff) for a pre-test interview in a confidential location. The pretest interview includes the following forms: Consent for Rapid HIV Testing (See *Appendix C* for form), Data Collection for the Interim Rapid Testing Form (See *Appendix D* for North Carolina Health Department required form), Completion of an assessment of risk of acute HIV infection (See *Appendix E* for Acute HIV Infection Screening Form).

The individual is not "checked-in" or registered as a client in the clinic in order to be tested, as it is free of charge (See Process Map Below). This is done to maintain simplicity of the process for the patient. Documentation of the encounter will occur through the use of Department of Health Off-Site Testing forms. The encounter and test results will also be recorded in a secure log to be kept by the clinic for record keeping purposes.

The HIV rapid test will be administered by the trained “tester” per the manufacturer’s instructions (the counselor and the tester may be the same or different staff members). The NC LINK sites used OraQuick® kits, provided by the NC Division of Public Health. The test device will be labeled in the presence of the patient with their initials. The client will be directed to the waiting room after the test is administered to wait for their results, which are available within 30 minutes. The tester is responsible for immediately taking the oral swab for processing in the designated testing area. Once the test result is available, they will call the client back for post-test counseling. The tester will provide the client with a result form to take with them once results are obtained.

- If the test is indeterminate, the client will be offered a repeat rapid test. If the second test does not yield an interpretable result, the client should be offered a blood draw which will be sent to the state public health lab. The tester should also notify the Clinical Quality Administrator or HIV coordinator who will report the case to the manufacturer.
- If the results are negative, the tester should explain the results and recommend future testing based on the client’s risk profile. The tester will also facilitate a risk reduction discussion tailored to the client risk behaviors. If the client has had exposures within 3 months, they may be acutely infected and in the window period (period after infection before an antibody develops). These individuals should be counseled to return in 3 months for retesting or to have a blood for HIV RNA. In NC this can be performed at the state public health lab. (Clinics may also offer HIV RNA testing onsite.)
- If the results are positive, the tester must ask another certified tester to read the device for quality control. The tester will also notify the clinic’s attending physician. If the test is confirmed positive by two different testers, the client will be given the results in a confidential location by a medical provider and offered two confirmatory testing options. The client can either register as a patient of the clinic and do testing through the clinic lab. Alternatively, the client can have a blood draw sent to the state public health lab.
 - A new patient appointment should be offered no later than 7 days after the confirmatory test results are available.
- If the client initially refuses confirmatory testing, the client will be strongly encouraged to do confirmatory testing as soon as possible at another location and is provided with a list of testing sites for future testing (Sites for HIV Testing Form). S/he will be counseled on the importance of abstinence or use of protection for all types of sexual encounters until s/he receives confirmatory testing results. The client’s information is provided to DIS as a positive rapid test result and decline of confirmatory testing by the HIV Coordinator.
- If the client has a preliminary positive HIV rapid test and leaves the clinic before receiving results, the client is contacted by clinic staff and recalled to clinic for notification of results. Negative results for clients who leave before the test has finished running can be provided over the phone and will only be done with a live caller (no voicemails) and after 2 client identifiers (name, date of birth) are verified.
- Counseling as appropriate to the client’s risk profile should be administered. If the client cannot be recalled to clinic and the result was positive, the HIV Coordinator will utilize the DIS system for assistance with notifying the client of the need for confirmatory testing. If the client chose to do the

confirmatory test at the clinic but cannot be reached for those results, the HIV Coordinator will work with DIS to recall the client for results discussion and next steps.

- If the client is overly distressed about a test result (positive or negative), the test counselor will refer and facilitate entry into counseling services with the assistance of other staff members as needed. This includes meeting with the clinic social worker or onsite psychologist if available. In extreme circumstances, the psychiatry or crisis management staff should be immediately contacted based on the judgment of the attending physician or designee in clinic.

For all positive results, the tester must complete the Interim Rapid Testing form and finalize this form once the confirmatory test results are returned. This form will be sent to the Department of Health. The HIV Coordinator will also complete a Confidential Communicable Disease Report for the new HIV case, per state law. The HIV Coordinator will also contact the Disease Information Specialists (DIS) about the new case and inform the client that they will be contacted by DIS per state law. If the client refuses confirmatory testing, this should be noted on the Interim Rapid Testing form. *See Appendix A for Standard Operating Procedures*

Training:

All testers should receive proficiency training in the test procedures by qualified trainers from the Department of Health or their designee. Additional refresher courses should also be provided as needed.

Testers will receive competency testing after initial training and annually, which will be documented in the tester's departmental employee file. Competency testing will include performance of a test on a blind specimen and observation of test administration by either the HIV Coordinator or the Clinical Quality Administrator.

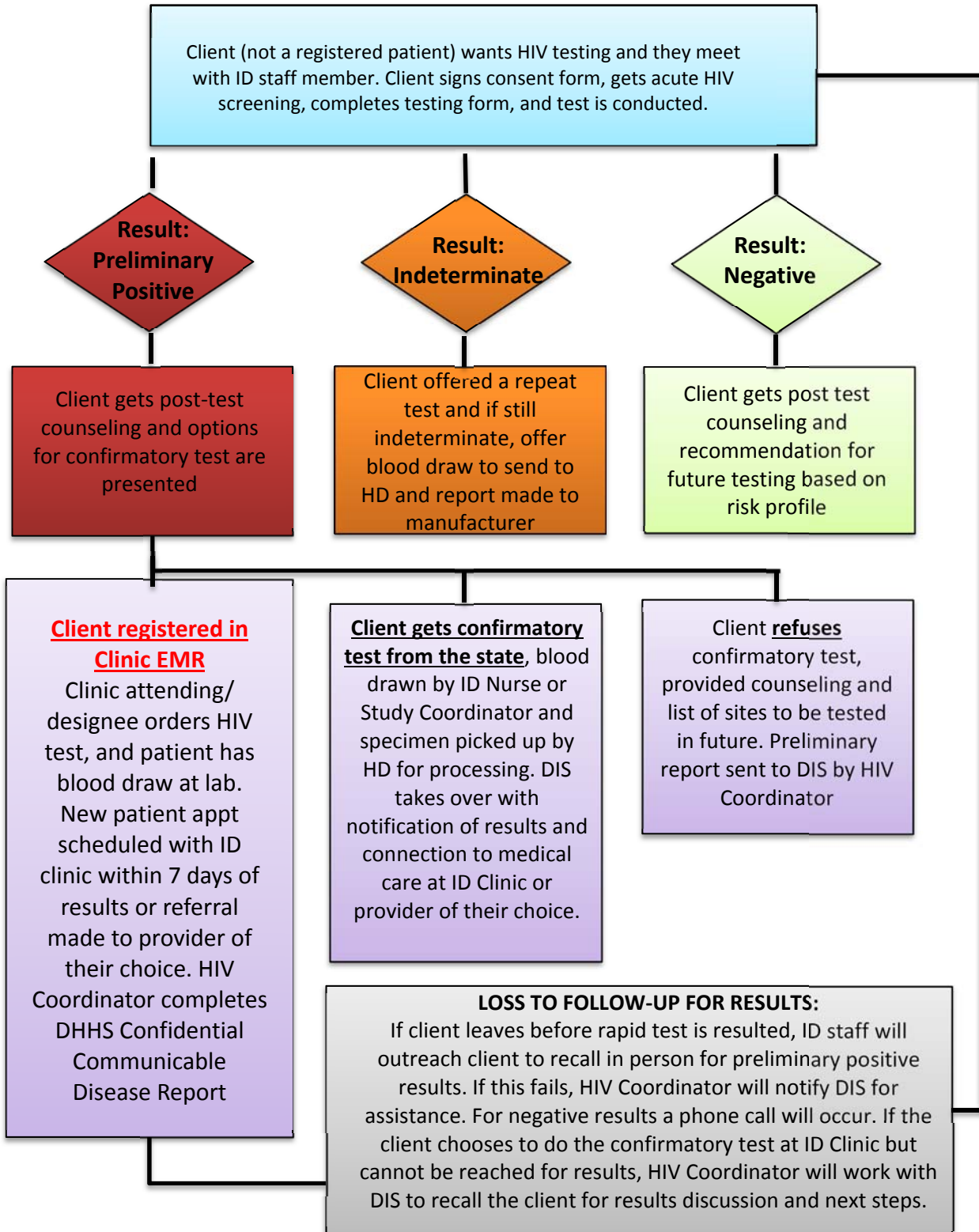
Quality Assurance:

Once staff are trained they must pass a written exam and an observational exam (where a certified tester observes the new tester conduct and read a test). Per the protocol, if a test is positive, it must always be confirmed by a second reader.

Controls are run routinely according to the manufacturer's instructions; when a new test kit lot is opened, when a new shipment is received with a different lot number, when a new tester begins testing for the first time, and if the temperature goes out of range in the storage area (35-80°F). Documentation of controls will be maintained in the control log.

The test kits will be stored and maintained according to the manufacturer's instructions. Temperature will be monitored daily and recorded in the test kit storage area.

HIV CLINIC-BASED RAPID TESTING PROCESS MAP



Pre-Implementation Activities:

It is important to note that while this section provides an overview of the specific requirements NC-LINK fulfilled for approval, a site considering replication of this program may have varying requirements. Anyone aiming to implement this intervention should fully understand their institution's policies on counseling and testing, including consent policies, point of care testing, and the processes for obtaining approvals from various institutional committees. As an academic medical center, the initial NC-LINK implementation approval process had significant administrative processes and oversight review procedures that may be less involved in a smaller site. If possible, the rapid clinic-based testing program should be implemented under an existing Clinical Laboratory Improvement Amendments (CLIA) license in order to facilitate the approval process. Establishing a partnership with the local health department is also critical to the success of this intervention. Having the clinic act as an alternative testing location for the health department enabled the client to be tested without registering in the clinic's electronic medical record system. This also made the approval process easier because there was no extra funding needed for the program as all of the tests were supplied by the health department.

Implementing the testing program had to be approved by a number of different divisions through a series of applications and presentations: Point of Care Testing Committee, Legal, Risk Management, Department of Nursing, Chief Nursing Officer (CLIA License Holder), Internal Medicine Leadership, Section on Infectious Diseases Chief, and Infection Control. The testing protocol had to be approved by the Joint Commission Waived Testing Standards, the clinics' institutional standards, the local county Department of Public Health standards, and the clinics' Section on Infectious Disease standards. A Memorandum of Understanding (MOU) was developed between the clinic and the department of public health (see *Appendix B*) to allow the clinic to serve as an alternative testing site for the health department. The legal concerns raised were making sure that the testing program had a process for follow up with anyone who tested positive and the legality of the clinic serving as an alternative testing site of the public health department.

The pilot site for the clinic-based testing intervention employed five different Plan-Do-Study-Act (PDSA) cycles to finalize the procedure. The first cycle defined the clinic-based testing protocol, the second cycle trained clinic staff on the protocol, the third cycle tested the protocol on three eligible individuals in the clinic (i.e. partners/contacts of current HIV patients who were interested in being tested and accompanied the patient to the clinic), the fourth cycle implemented the protocol in the entire clinic and the fifth cycle developed marketing strategies for the testing program. During each cycle, the protocol was observed and any issues were documented. Changes were then made before implementing the next PDSA cycle.

Lessons Learned:

The Clinic-based HIV testing intervention pilot site revealed the following lessons learned:

- Collaboration with the local and state health departments is critical, particularly to leverage resources. For the purposes of this intervention, the clinic served as a satellite clinic of the local health department. This allowed the clinic to avoid having to register the client as a patient, enter a client in the electronic medical record system or generate a charge for the service. In addition, the local health department provided the HIV

training for pre and post-test counseling and test kit use and interpretation of results, as well as the free test kits.

- Marketing of the testing program by clinic staff encourages testing.

Training the front line clinic staff (e.g. nurses and medical assistants) to ask patients, “Is there anyone here with you today who would like to be tested?” was found to encourage people to test. A personal approach, combined with flyers in the clinic, proved to be most effective.

- HIV testing may be utilized as a link back to treatment.

A number of patients who participated in the intervention were *known positives*. These patients were aware of their HIV-infected status before receiving the HIV test and admittedly re-tested in order to receive an immediate and personal referral back to HIV care. These patients were promptly scheduled for medical appointments.

- Conducting a clinic-based testing intervention in a large academic medical center may require a lot of administrative oversight and time for approval.

Understanding an institution’s policies on counseling and testing is important for approval and gaining the appropriate approvals takes time. In contrast, smaller sites may not have as many administrative processes to go through and may have an easier time getting a clinic-based HIV testing program approved.

- Implementing a new testing program under an existing Clinical Laboratory Improvement Amendments (CLIA) license may make the approval processes easier as CLIA certification can be a lengthy process.

2. State Bridge Counseling Linkage Intervention

Target Population: Newly-diagnosed HIV-infected patients

Target Audience for Intervention Implementation: State Bridge Counselors and staff involved in state bridge counseling

Intervention Aim & Rationale: Improve linkage to care by confirming newly-diagnosed HIV patients attend their first scheduled medical appointment and addressing any barriers to care initiation as needed.



This intervention provides services to those who have been recently-diagnosed and not yet linked to care. The intervention directly addresses creating linkage to care, which helps initiate ARV therapy and decreases the risk of transmission of the disease to others. Additionally, there are Special Populations State Bridge Counselors (SPSBC) that work with high-risk populations: pregnant women and post incarceration releasees.

It focuses on the objective of the National HIV/AIDS Strategy to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care. This intervention can also impact client retention, ARV therapy, and viral suppression, as identifying and linking and retaining new patients in care and starting them earlier on therapy can have a great impact on the remaining steps of the cascade.

Overview of Services:

The primary role of the State Bridge Counselor (SBC) within this intervention is to link PLWH to HIV Care. The SBC also plays a critical role in educating patients about the HIV disease process and removing barriers to initiating care (e.g. transportation, insurance, denial of diagnosis, etc.). For the linkage portion of the SBC intervention the SBCs work to link newly-diagnosed clients to care, defined as clients who are first diagnosed with HIV infection during the previous 180 days. The SBCs may also work with new to care clients who have been previously diagnosed with HIV, but not previously linked to HIV medical care.

New to care clients can be referred by anyone, but newly-diagnosed clients are typically referred by the Division of Public Health's Disease Intervention Specialists (DIS). DIS receive lab reports for each newly diagnosed or newly reported individual for partner notification services. At the time of the client meeting with the DIS, if possible, the DIS schedules the first medical appointment and then transfers follow-up responsibilities to the SBC. The role of the SBC is then to confirm that the client attended the medical appointment. If the appointment is confirmed, the SBC does not provide client services but closes the case (confirmation only). If the medical appointment was not attended by the client, the SBC assists the client in rescheduling and attending a medical appointment. The SBC also confirms that there are no barriers to attending future appointments. If the client does have barriers, the SBC works to address the barriers and link the client to care and provides solutions to logistical problems such as transportation and/or lack of insurance.

The Special Populations State Bridge Counselor (SPSBC) for NC provides assistance in the transition to care for any person who has HIV/AIDS and is a prison releasee and/or pregnant woman. This position networks with the regional HIV care programs including DIS, private providers and case managers, while also serving as a link between HIV-diagnosed individuals and the regional HIV care network. Additionally, this position works very closely with jail and prison staff to identify and provide services, as needed, to HIV-infected inmates upon their release. Otherwise the SBC for these special populations performs similar roles, functions and tasks as the other SBCs.

When working with clients, the SBC may identify client needs that are not directly linked to preventing engagement in HIV medical care. The SBC takes the lead in facilitating referrals to other members of the care team or other local ancillary care providers who are able to address these needs.

Key Components of Intervention:

Staff required:

As part of NC-LINK, the NC Division of Public Health, Communicable Disease Branch manages and provides oversight to the funding (from a variety of sources), hiring and personnel management of the SBCs. Each RW care region in the state has an assigned SBC.

The NCDPH, Communicable Disease Branch also provides oversight to three Special Populations State Bridge Counselors. The primary focus of these positions is to target HIV-infected inmates upon release from incarceration, their partners, and HIV-infected pregnant women. These bridge counselors are in areas of high need and denser populations. Currently there is one special populations SBC in Charlotte, one in Raleigh, and one in Winterville.

A critical aspect of the State Bridge Counselor position is the ability to interact with and build relationships of trust with PLWH. As such, each bridge counselor must be culturally sensitive, non-judgmental, and skilled in active listening. Additional skills necessary include: attention to detail, ability to make independent judgments consistent with training and protocols, advanced level of current disease knowledge, understanding of HIV provider care networks as well as skills in client interviewing and client-centered counseling. See an example job description in *Appendix I* and *J* for more specific required characteristics and training/background.

EMR/Data Tracking:

Access to multiple HIV surveillance/care software programs is critical to the SBC workflow, primarily NC EDSS and CAREWare. NC EDSS is used by the DIS to refer newly-diagnosed or new to care clients to the SBCs. The SBCs use the Bridge Counselor package in NC EDSS to track all efforts to find and engage clients in initial care. Additionally, the SBCs enter their linkage activities in CAREWare and provide definitive outcomes on each client referred for linkage services. SBCs use both NC EDSS and CAREWare to aid in locating clients.

Protocol:

All newly-diagnosed HIV-infected clients reported to the Regional DIS office (new infections and previous infections newly reported in NC) will be referred to the SBC through the Bridge Counselor Package in NC EDSS to ensure that they attended the initial clinic visit (from the DIS referral) or are subsequently seen by a prescribing

provider within 60 days of the appointment date. Every newly-reported case will be tracked by the SBC until attendance at the first medical visit with a prescribing provider is confirmed.

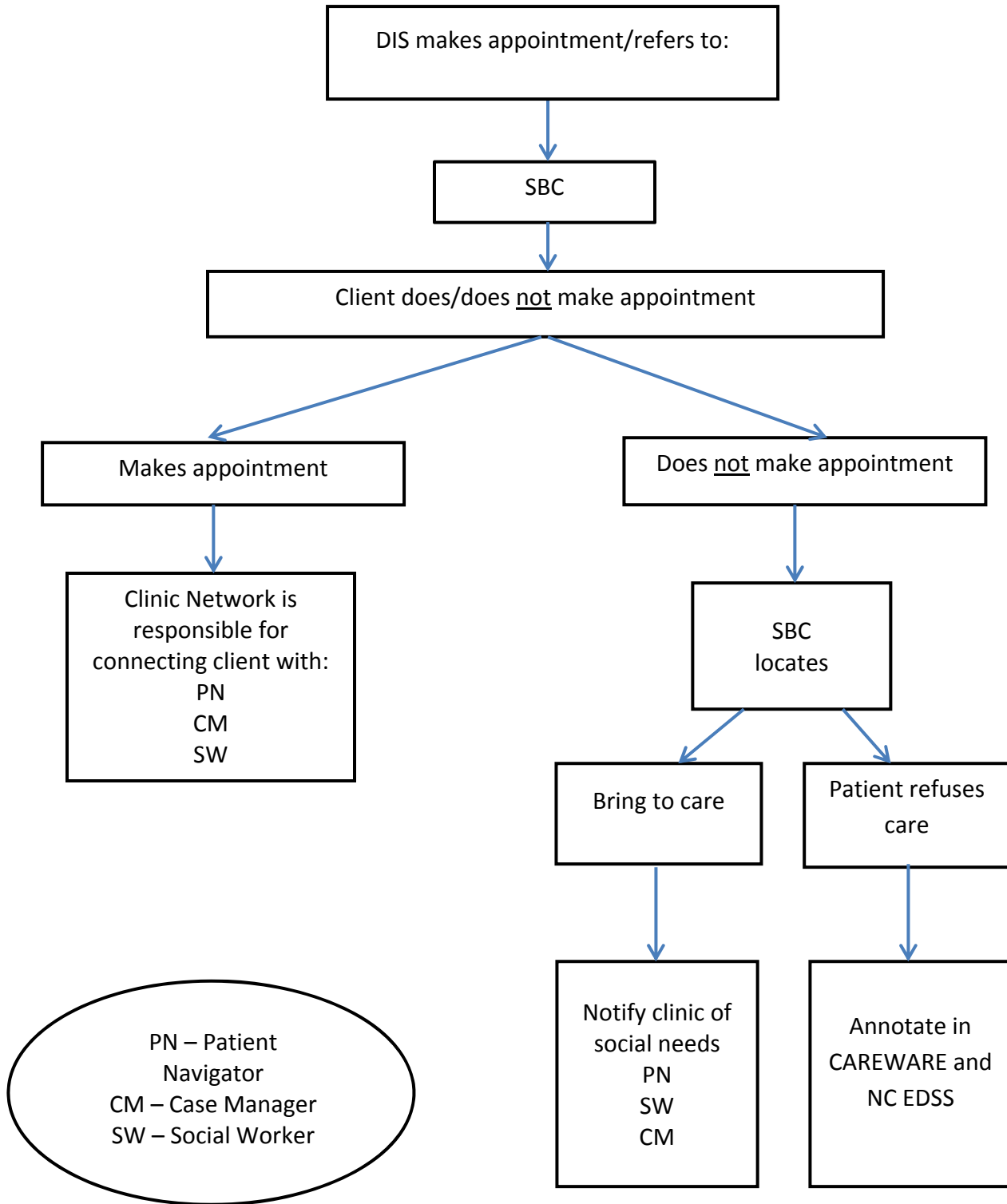
If the client did not attend the appointment, the SBC will contact the client to address what prevented him/her from attending the appointment. Attendance confirmation should be documented in electronic databases, thereby minimizing efforts to contact the client and/or provider's office. When the client is located, the SBC will use strengths-based training to address and overcome any barriers the client presented to attending their appointments. The SBC will close the case after 90 days if unable to contact the patient.

Special Populations:

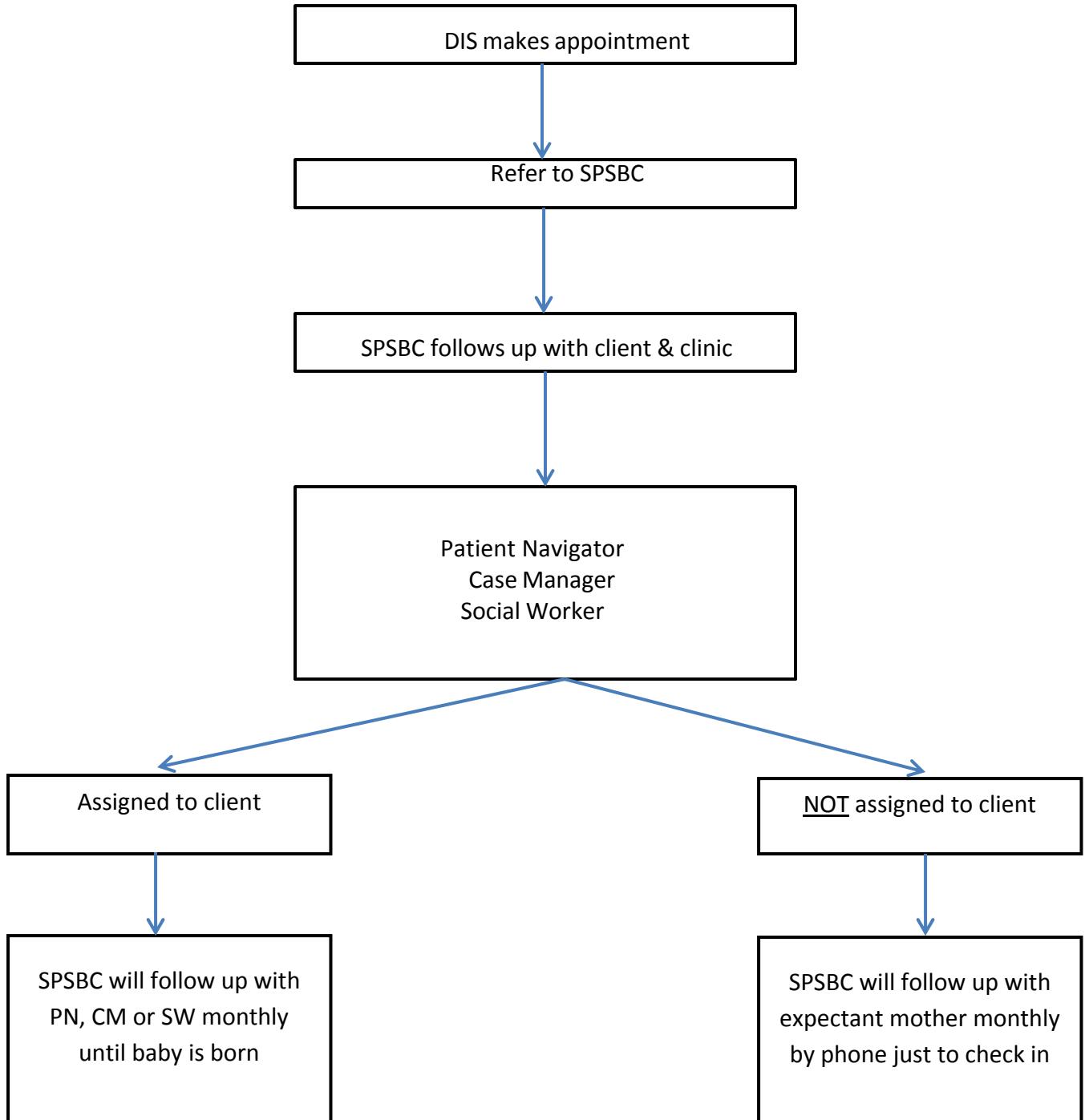
DIS and other SBCs will refer pregnant women who have not been linked with care or are out-of-care to the Special Populations Bridge Counselor (SPSBC). For newly-diagnosed pregnant females, DIS will complete the Referral Package in NC EDSS and assign the client to a SPSBC within 24 hours of initial contact. For women who accept care referral, DIS will provide transportation to initial medical appointment and explain that the SPSBC will contact them after their medical appointment. The SPSBC will follow up with pregnant HIV-infected women or their Case Manager/Social Worker on a monthly basis to ensure the client remains in care and on meds, until she delivers her baby. If the pregnant woman did not accept a care referral to the SPSBC, the SPSBC will still follow up with the expectant mother monthly by phone to check in.

For prison releasees, the corrections nurse makes the client's initial medical appointment after release and notifies the SPSBC of the prisoner's imminent release. If given enough notice, the SPSBC will meet the releasee at prison and provides service information for their area of release. The SPSBC will check on the releasee within 48 hours after release from prison and after their first medical appointment to make sure the appointment was attended. If the client did not attend their medical appointment, the SPSBC attempts to identify and overcome barriers to care.

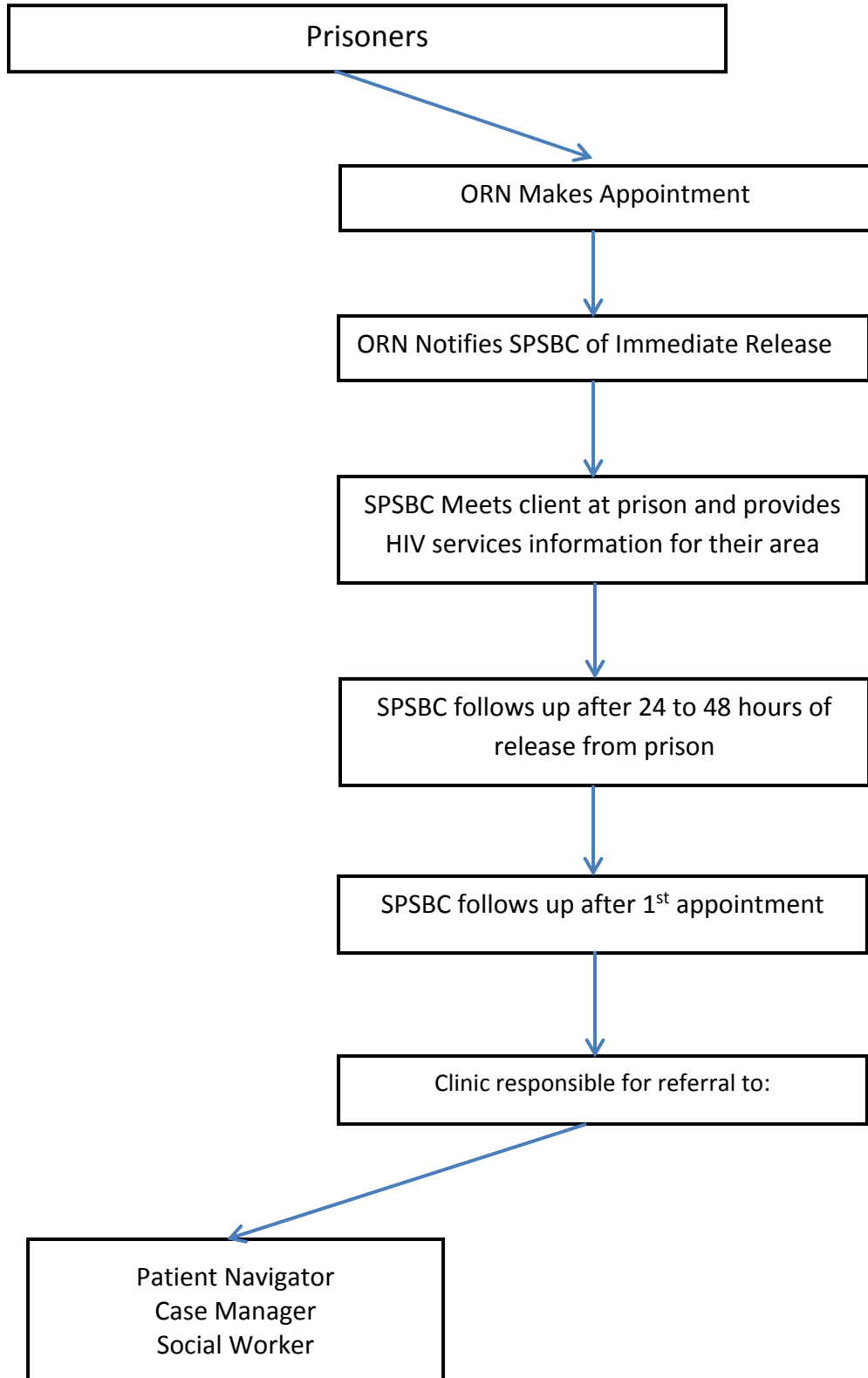
NEW HIV DIAGNOSIS



PREGNANT WOMEN



POST-INCARCERATION



Training:

All SBCs have received training on field work, substance abuse and mental health, and resistance/barriers to care. The following specific trainings must be completed by SBCs: CDC's *Introduction to Sexually Transmitted Disease Intervention* (2 weeks), *HIV Prevention Counseling* (3 days), *NC HIV Interviewing and Partner Notification* (1 week), *Cluster Intervention* (2 days) and *STDMIS 3.1* (1 day computer program course).

In addition, each SBC is trained in Anti-Retroviral Treatment and Access to Services (ARTAS), which is an evidence-based, individual-level, multi-session, time-limited intervention with the goal of linking recently-diagnosed persons to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology.⁶ SBCM is a model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the bridge counselor. Specifically, the ARTAS core elements include:

- Build an effective, working relationship between the Linkage Coordinator (SBC) and each client
- Focus on the client's strengths by:
 - Conducting a strengths-based assessment
 - Encouraging each client to identify and use his/her strengths, abilities, and skills to link to medical care and accomplish other goals.
- Facilitate the client's ability to:
 - Identify and pursue his/her own goals
 - Develop a step-by-step plan to accomplish those goals using the ARTAS Session Plan (This is not a required component of the SBC Program, although the SBCs should use the ARTAS paperwork at their discretion)
- Maintain a client-driven approach by:
 - Conducting between one and five structured sessions with each client (The SBC Program does not mandate minimum or maximum in-person sessions)
 - Conducting active, community-based case management by meeting each client in his/her environment and outside the office, whenever possible
 - Coordinating and linking each client to available community resources, both formal (e.g., housing agencies, food banks) and informal (e.g., friends, support groups, spiritual groups) based on each client's needs
 - Advocating on each client's behalf, as needed, to link him/her to medical care and/or other needed services⁷

The North Carolina State Bridge Counselors try to adhere to the ARTAS core elements as much as possible. However, the program is not dependent on full ARTAS implementation nor is this expected to occur. The SBCs are asked to incorporate the components of ARTAS that are relevant to strengths-based work with out-of-care clients.

To schedule ARTAS training on-site, a request must be made through the state health department to the CDC/Danya International. A minimum of 10 participants must be available to attend the three-day training.

For more information on ARTAS training visit:

<https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/ARTAS.aspx>.

Pre-Implementation Activities

The SBC linkage program underwent five PDSA cycles between each of the three learning sessions held in years 1 and 2 of the NC-LINK project. The first cycle developed and implemented the SBC process standards; the second cycle tested and modified the SBC Patient Information Form to use in the field; the third cycle modified the ARTAS process and implemented it in two regions; the fourth cycle tested the referral process from the regional site using the retention protocol, and the fifth cycle tested the CAREWare referral strategy for the retention protocol intervention.

An SBC workgroup was also developed in Year 2 with representatives from the NC Department of Health and Human Services, Duke, UNC, and the SBCs. The workgroup developed a set of process standards (see Appendix F) for the SBCs to follow. These standards were then revised to expand on the referral process for newly-diagnosed HIV-infected patients and priority groups for lost-to-care patients. These revisions were reviewed and edited by the SBC team before being implemented in the PDSA cycle.

Lessons Learned:

The State Bridge Counselors Linkage intervention revealed the following lessons learned:

- Having the DIS serve as the first point of contact helped reduce SBC caseload

Initially, the SBSs were overwhelmed by the high volume of referrals from DIS. By having the DIS first make contact with the patient and schedule a medical appointment, the caseloads for the SBCs decreased. For each referral, the SBCs then only needed to perform first appointment verification. This enabled the SBCs to concentrate on locating the clients who did not attend their first appointment and focus on linking them to care.

- Standardizing the SBC program and SBC duties was extremely important

Developing a set of performance standards as well as standardizing the training and protocols for the SBCs helped differentiate the SBCs from DIS. Additionally, there was a fair amount of staff turnover as well as a staggered hiring schedule for the SBCs. Having standardized materials and training helped ease this process and ensure SBCs all had the same guidelines. Part of the standardization process for the SBCs also included organizing all of the SBCs under one primary supervisor, instead of separate supervisors for each of the regions. This helped ensure that the SBCs were all receiving the same instructions and following the same protocol.

- Finding out about the prisoner's release date in advance was better than waiting until s/he was released

Due to the complicated process of releasing a prisoner, the SPSBCs often missed making contact with the prisoner if they waited until the time of release. This made it more time consuming and strenuous for the SPSBC to then attempt to locate the prisoner after release and increased the prisoner's chance of being lost to care. Having the Outreach Nurses at the prison work on linkage six months in advance with the SPSBCs allowed for a more seamless transfer of HIV care from the prison to the community.

3. Retention Protocol Intervention

Target Population: HIV-infected patients who are out of care, defined as an active patient who has not had a medical visit in 6-9 months or more

Target Audience for Intervention Implementation Staff of medical clinics serving people living with HIV/AIDS

Intervention Aim & Rationale: Improve retention by re-engaging patients identified as out-of-care.



This intervention provides services to those who have been linked to care, but are not consistent users of care. The intervention directly addresses retention in care, which helps get patients back on ARV therapy, leading to increased rates of viral load suppression.

Following one of the key objectives of the National HIV/AIDS Strategy, the intervention attempts to increase the proportion of Ryan White HIV/AIDS Program clients who are retained in continuous care. It also impacts all steps of the cascade; by targeting out-of-care patients who may be spreading HIV to uninfected partners, new networks are created of individuals who need to be identified, diagnosed, and rapidly linked to care.

Overview of Services

This strategy utilizes CAREWare to develop the capacity of regional bridge counselors/patient navigators and medical clinic staff (collectively referred to as ‘retention staff’) to run monthly CAREWare or EMR reports to identify HIV patients who have not had an appointment in the previous 6-9 months and do not have a scheduled appointment. The retention staff then follows a standardized protocol to locate and re-engage these patients. Additionally, they use CAREWare to track their efforts and electronically refer to partnering staff members/organizations and SBCs. This strategy can be tailored to individual sites.

It is critical that a site intending to replicate this intervention agrees upon a defined time frame for out-of-care. The pilot site tested the process for identifying, attempting to locate and then referring lost-to-care clients (clients who are out-of-care and who were not retained in care using the clinic retention staff) to the State Bridge Counselor. This site opted to use a nine-month time frame to identify a client as out of care. Additional expansion sites in the project decided to adhere to the HRSA HAB measure for out-of-care, which is defined as six months without an appointment with a medical provider. Running out-of-care lists on a six-month time frame will yield more patient names and may include a higher proportion of patients who aren’t fully out of care with upcoming appointments. However, it will also allow retention staff to identify patients who are likely to fall out of care and catch them before they do. Conversely, using a nine-month timeframe will lessen the number of patients on the out-of-care list making it more manageable for retention staff, but may result in more patients who fall out of care and are more difficult to locate. The timeframe to use will be specific for each site.

Key Components of Intervention:

Staff required:

A designated staff member who has access to CAREWare and the clinic's EMR is necessary for running the out-of-care list. This person may be a clinical or administrative employee.

Retention staff at the clinic level are necessary to attempt to reengage the client before referring to a state bridge counselor. Retention staff may be called Patient Navigators, Medical Case Managers, Access Coordinators, or Linkage Retention Coordinators. *See Appendix Q for an example job description.*

Electronic data system:

An electronic data system, and/or EMR are required to run the out-of-care list. Sites in NC-LINK use both CAREWare and Epic data systems. CAREWare allows the creation of custom field for retention activity documentation that may be subsequently shared with SBCs if the retention efforts are unsuccessful. However, the clinic's primary EMR will have information about future appointments which will allow elimination of individuals with future appointments from being placed on the out-of-care list unnecessarily. This is a key decision for an implementing site.

Protocol:

On the same day each month (e.g. 1st of the month) the clinic generates a list of out-of-care clients (those who have not had a medical care visit in 6-9 months or more) through either clinic EMR or CAREWare (CW). The staff member responsible for running the list then checks the list to remove clients who are not truly out-of-care due to special circumstances or who have upcoming appointments (if not using the EMR to filter out these individuals) .

The clinic-based regional retention staff receive the revised out-of-care list from clinic via an electronic CAREWare referral. The retention staff work on locating client for roughly 30 days before referring clients to the SBCs. The primary difference between the retention staff and the SBCs is that the retention staff's work is primarily conducted from their respective clinic or agency, not through fieldwork. Retention staff search for clients through the following activities, all of which should be documented in CAREWare:

- Check EMR/local CAREWare for any contact since the last medical visit.
- Call patient's home/cell/work numbers in the chart as well as any old numbers that are in the chart in case they are active again. Three phone calls on three separate days is the standard, using all available numbers and contacts.
- Leave generic messages for callback. [Establish script for training and consistency.]
- Conduct internet search of local jails, state prisons, federal prison system.
- Check the Social Security Death Index and perform a Google search for potential obituaries and other information about the patient.
- Check the NC Medicaid Provider Portal (if patient has Medicaid) to see if they have been in care elsewhere, accessed EDs or had an inpatient stay, and if there is different contact info in the record.
- Call last pharmacy (including ADAP) and see if any other refills have occurred since last medical visit and get any contact info available or info on other prescribing providers.

- Call any home health agency/dialysis center/or other provider (including dental) identified to obtain current contact info or get a message through to the patient.
- Send out a generic letter to last known address encouraging the patient to contact the clinic if no phone calls have been successful. [Conversely, letters may be sent initially and then calls are placed for those who do not respond to the letter.]

After 30-day time period of attempts to locate, the retention staff member documents the efforts and provide service and outcome information via CAREWare. The clinic then closes out clients who have been located or a definitive outcome has been determined. Outcomes documented include:

- Re-engaged in care at referring provider
- Re-engaged in care with new provider
- Deceased
- Re-located
- Incarcerated
- Located, not re-engaged in care to-date
- Unknown-not located

“Located, not re-engaged in care to-date” and “Unknown- not located” clients are referred to the State Bridge Counselor for state-level follow-up and field work.

Each clinic should establish individual procedures for re-engagement (see Figure 4 below). The following items should be outlined within the clinic procedures:

- What attempts will the clinic make to re-engage the OOC client? (e.g. phone calls, letters, search databases, etc.)
- How many calls/attempts should the clinic staff make and for how many days?
- When should the clinic staff refer the client to a State Bridge Counselor?
- Scripts for leaving messages and template letters.

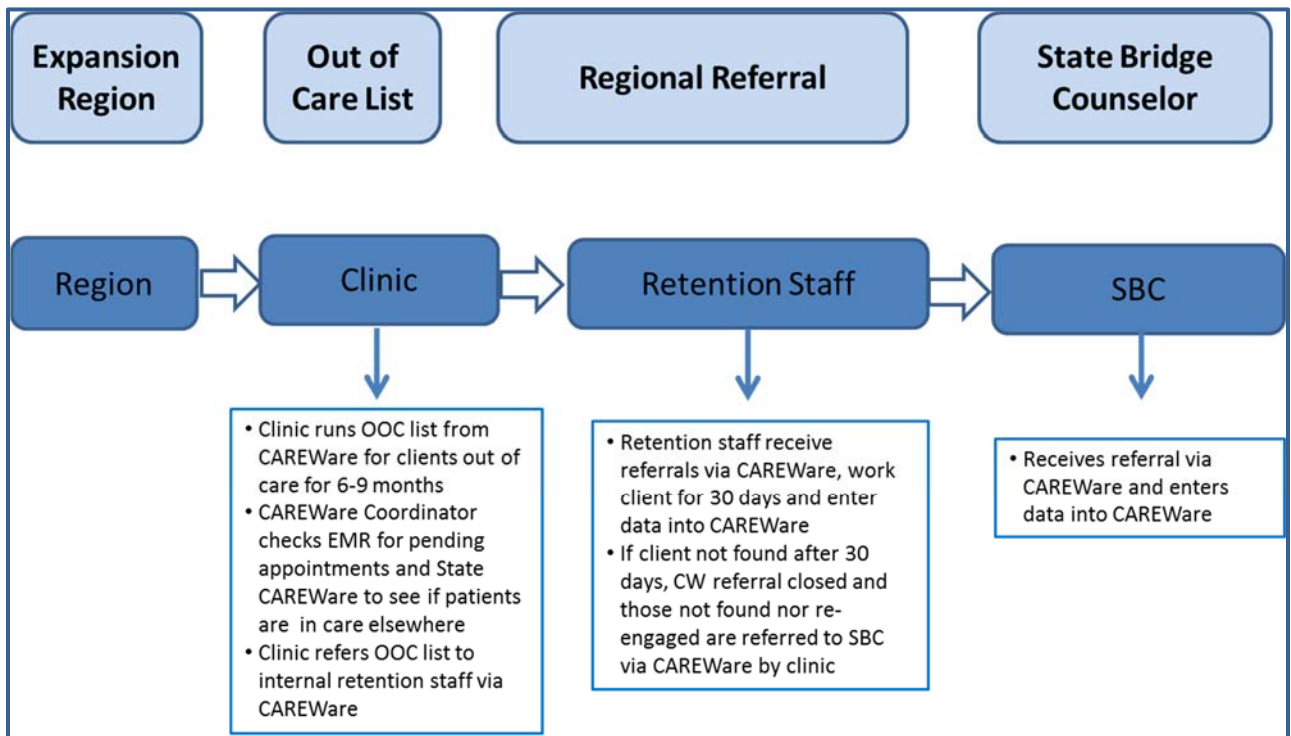


Figure 4. Sample flow process for Retention Protocol

See Appendix M, N and Appendix P for sample retention protocol and intervention detail. See Appendix O for documentation checklist.

Training:

Retention staff should be trained in the clinic’s EMR, CAREWare (specifically in custom report creation), and Excel. Additionally, staff should be trained on the clinic’s protocol including creating the out-of-care lists and the protocol for referring out-of-care patients to the appropriate State Bridge Counselor.

Retention staff should also be trained on what resources to use when looking for patients (i.e. internet sites, registries, prison/jail databases, etc.) They should also receive medical case management training. Additionally, it is important for retention staff to meet with their region’s SBC to develop a beneficial working relationship and ensure each’s efforts are most effectively utilized.

Pre-Implementation Activities

Five different PDSA cycles were employed before expanding the retention intervention. The first cycle developed the retention protocol, the second cycle defined “out-of-care” and developed the protocol for generating the out-of-care list, the third, fourth, and fifth cycles implemented the retention protocol at three different sites (large academic medical center, community-based case management agencies, and with the SBCs). The protocol was revised and refined at each stage of implementation.

The retention protocol led to increased communication between SBCs and regional retention staff, and defined the steps retention staff should take to locate the client before referring them to the appropriate SBC. In

addition to other activities, one of these steps included the development of a no-show policy for each site for patients who had scheduled medical appointments but failed to cancel/reschedule the appointment in advance. This helps prevent patients from falling out-of-care and reduces the number of clients who need to be referred to the SBCs. It also allows clinics to reach patients early on when they miss appointments (sometimes the same day or a few days following), as opposed to many months later.

The process of referring out-of-care clients to SBCs was also developed and honed. The advantages and disadvantages to using phone calls, secure fax, in-person exchanges and CAREWare were evaluated. It was eventually decided to use an electronic referral process through CAREWare, a required software for all Ryan White Part B providers in NC. A CAREWare policies and procedures workgroup was established to develop security practices and user guides for CAREWare. The CAREWare User Guide is attached as a separate Appendix.

Lessons Learned:

The retention protocol intervention pilot sites revealed the following lessons learned:

- The protocol should allow for varying time frames (e.g. 6-9 months OOC) but must be consistent at each site so that the same time frame for OOC is measured for each patient/client.

We found that each pilot site had its own preference for the timeframe of the out-of-care lists. While some preferred to generate their lists based on six months out-of-care, others preferred nine months out-of-care. Although each timeframe has advantages and disadvantages, clinics could choose to use either, as long as each clinic was consistent and used the same timeframe each time, ensuring that all clients out-of-care for the designated timeframe were accurately captured. In addition to using a consistent timeframe, each clinic needed to generate the out-of-care list at the same time each month. So whether the clinic wanted to run the list on the first of the month or the last day of the month, that date needed to stay consistent in each clinic as well.

- Improvements in the retention staff enhanced communication between retention staff and SBCs.

We discovered early on that the roles and responsibilities of the regional retention staff as compared to the SBCs needed clarification and further explanation. Developing a protocol for the retention staff and the SBCs helped clarify the activities the retention staff should perform from the clinic to locate clients and when they should refer clients to the SBCs. The protocol also helped create transparency by requiring documentation of the work the retention staff were doing to locate the client in CAREWare. This made it easier for the SBC to follow the progress made when they received a referral and avoid duplicating work.

- A no-show/cancellation policy also helps identify patients at-risk for becoming out-of-care.

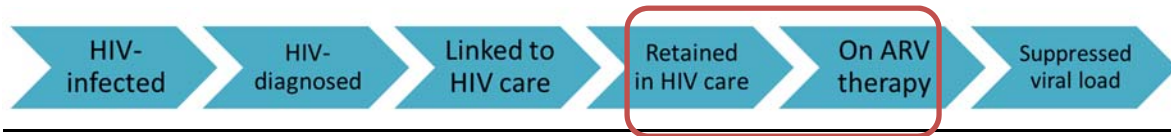
Developing a policy of calling and rescheduling patients who missed their appointment helped keep clients from falling out of care and helped decrease the size of the out-of-care list. Clients who are rescheduled after missing an appointment should not appear on the out-of-care list. The list should decrease monthly as OOC clients are located, re-engaged in care, or cases are closed. The only clients who should remain on the out-of-care list are those who could not be located or were not re-engaged in care. This is the list that should then be referred to the SBCs for further fieldwork.

4. State Bridge Counseling Re-engagement Intervention

Target Population: HIV-infected patients who are out-of-care, defined as having missed an appointment and not re-scheduled or re-engaged within 6-9 months

Target Audience for Intervention Implementation: State Bridge Counselors and staff involved in state bridge counseling

Intervention Aim & Rationale: Improve retention by re-engaging patients identified as out-of-care and not linked back from the retention protocol.



This intervention provides services to those who are linked to care, but are not consistent users of care and have been unable to be linked back into care via local retention efforts. The intervention directly addresses reengagement in care, which helps get patients back on ARV therapy, leading to increased rates of viral load suppression.

It focuses on the objective of the National HIV/AIDS Strategy to increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care. It also impacts other areas of the cascade; out-of-care patients can potentially spread HIV to uninfected partners, creating new networks of individuals who need to be identified, diagnosed, and rapidly linked to care.

Overview of Services:

The SBC's role is to re-engage PLWH in HIV care. Lost-to-care (LTC) clients are those who have not attended an HIV medical visit during the previous six to nine months or more, for whom a future appointment is not scheduled, and the reason for being out of care is unknown or beyond the capacity for local clinics/agencies to address.

For LTC patients referred by retention staff, the SBC works with the retention staff to determine what attempts to locate/engage the client have already been made. The SBC then conducts field work and statewide networking to locate the client and re-engage in care. Through strengths-based counseling and motivational interviewing techniques, the SBC identifies and attempts to address barriers that have prevented clients from linking to and/or engaging in HIV medical care.

When working with clients, the SBC may identify client needs that are not directly linked to preventing engagement in HIV medical care. The SBC takes the lead in facilitating referrals to other members of the care team or other regional providers who are able to address these needs.

Key Components of Intervention:

Staff required:

As part of NC-LINK, the NC Division of Public Health, Communicable Disease Branch hires and manages the SBCs to ensure that each prevention/care region has a dedicated SBC.

Collaboration between the SBC and other service providers (such as medical providers, case managers and retention staff) working with the client is imperative to achieve client linkage to and retention in care and avoid service duplication. The SBC fosters collaboration through regular communication, information sharing, and case conferencing with service providers throughout the provision of SBC services.

A critical aspect of the SBC position is the ability to interact with and build relationships of trust with PLWH. As such, each bridge counselor must be culturally sensitive, non-judgmental, and skilled in active listening. Additional skills necessary include: attention to detail; ability to make independent judgments consistent with training and protocols; advanced level of current HIV knowledge; understanding of HIV provider care networks; and skills in client interviewing and client-centered counseling. See an example job description in *Appendix I* for more specific characteristics and training required.

EMR/Data Tracking:

In NC, several software programs are critical to the success of the SBC intervention, the primary of which is NC EDSS and CAREWare. Clinic or region-based retention staff make out-of-care referrals through CAREWare, which the SBCs use to track their efforts and communicate with retention staff. The SBCs also document their activities and close cases through NC EDSS. CAREWare and NC EDSS are used to help locate clients who are out-of-care, as well as other state or federal databases (Department of Corrections, Medicaid, etc.).

Protocol:

Each SBC will meet with the Regional Network of Care (RNC) provider beforehand to understand internal policies and procedures for record searches and locating clients who have been lost-to-care prior to referral to the SBC. The SBC is also charged with attending the RNC quarterly meetings and may attend additional regional meetings such as Quality Management (QM), task force meetings, or any focus groups that would benefit out-of-care service re-engagement.

The referral from the care providers will be provided, at a minimum, through monthly CAREWare referrals or face-to-face meetings with the SBC.

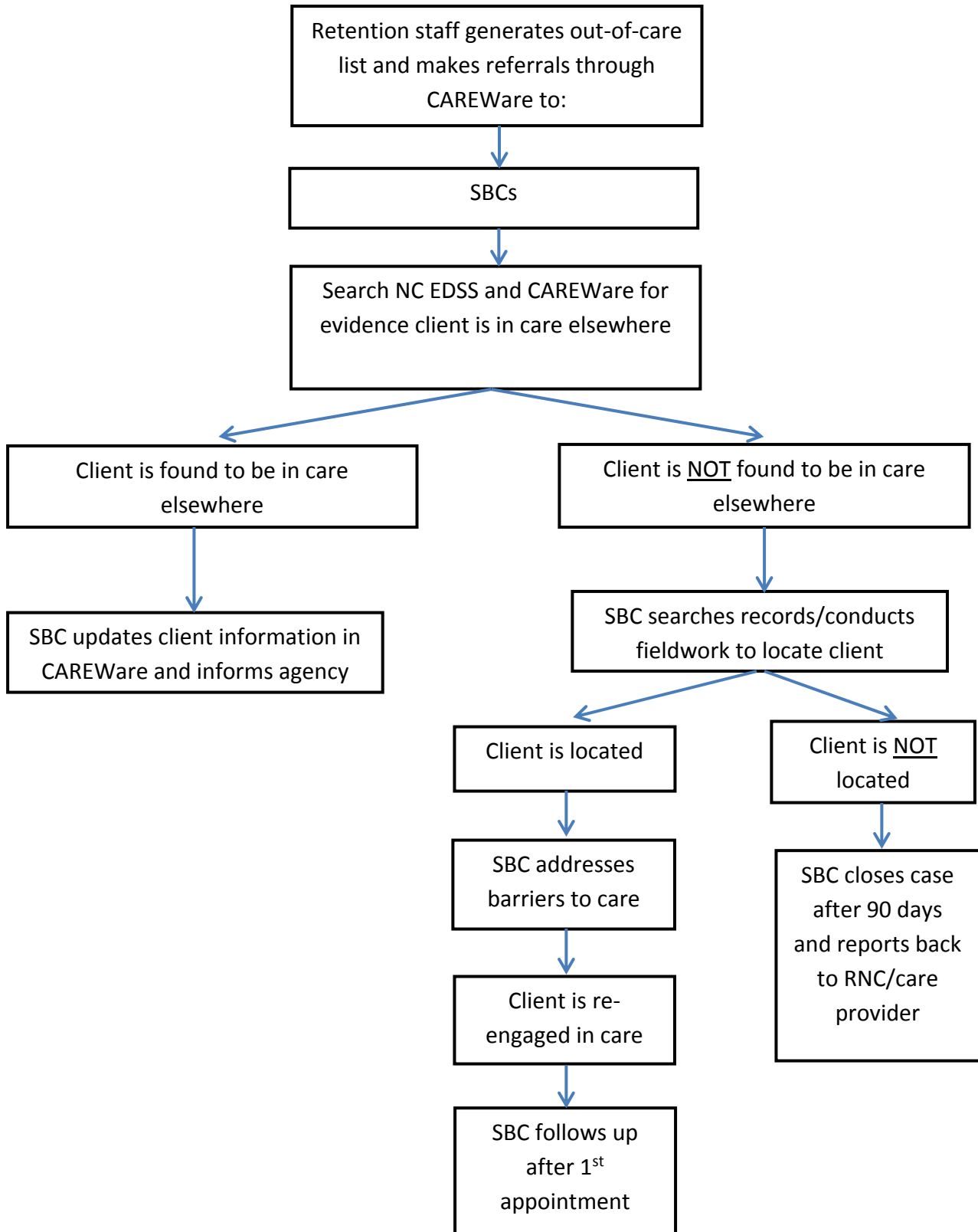
Pregnant women and post-incarceration HIV clients are designated as "special populations" and are prioritized by the SBCs upon referral from the RNCs and be sent to one of the Special Populations State Bridge Counselors. Other patients who are a higher priority are those with low CD4 counts and high viral loads.

After receiving a referral, the SBC determines the patient's care status with the following steps:

- Searches NC EDSS and state-wide CAREWare for any evidence that the patient is in care at another agency.

- If there is any evidence of recent testing or medical visits in NC EDSS or CAREWare, the SBC will confirm that the patient is in care with that provider, if the provider is located within the SBC's geographic region. If not, the SBC will contact the SBC who covers the area the agency is located in to confirm the person's care status. Ensure that the provider is an HIV provider, not an urgent care or ED provider.
- If the patient is confirmed to be in care at another provider's office, the SBC updates the referring agency of the change in medical provider within four weeks by documenting this in CAREWare.
- If the patient is found to be in another region, the current SBC will assign the case to the appropriate SBC who will receive the referral in the NCEDSS BC Package and in CAREWare. Once the new SBC has updated their attempts in the BC Package and submitted for closure, the referring SBC will then update the referring provider of the status and submit their section in the BC Package for Supervisor's approval.
- If there is no evidence that the person is in care anywhere else, the SBC will prepare the person's information for the field and attempt to locate the client.
 - Record searching CAREWare, NC EDSS, ADAP, Medicaid and the internet (i.e. 411.com, NC court calendar, NC voter registration, Facebook, Google, NC Department of Corrections, etc.) for additional locating information.
 - Within one business day of receiving the referral, the SBC begins the field work by calling any available phone numbers (the patient's and emergency contacts) and/or visits the last known address following standard DIS field follow up protocol (i.e. three field visits at different times of day, phone calls at different times of day, etc.).
- Once a patient is contacted, the SBC inquires as to what events or difficulties preceded the fall out of care (i.e.-transportation, loss of insurance, etc.) and offers opportunities to overcome these obstacles to care.
 - The SBC will recognize and respond appropriately to problem indicators by providing targeted motivators for the client to enter or re-enter care using strength-based counseling methods and techniques learned from ARTAS training.
 - If the patient is willing to be re-engaged in care, an appointment is set. Information on the appointment should be entered in the Referrals Package in NC EDSS.
 - If the patient declines to go back to care at the time of the interview, the SBC discusses the reasons for this choice and attempts to address those issues. If the patient is still resistant, the SBC informs the referral source of the patient's refusal and updates all attempts made in the BC package.
- After the patient attends the medical visit (with an ART-prescribing provider), the SBC will follow-up with a phone call to the patient to determine if a follow-up appointment has been made and to address any barriers to remaining in care. If the SBC is unable to contact the patient, the SBC will confirm using CAREWare or lab data that the patient kept the medical appointment and scheduled a follow-up appointment.
- When the appointment has been attended, the appointment should be documented in the Referrals Package and the case should be closed and submitted to the Supervisor in the BC Package of NC EDSS. The case is also closed in CAREWare.

OUT OF CARE



The SBC will work with HIV care providers and DIS for any HIV-infected persons reporting risky behaviors. To maintain distinction between the DIS and the SBC, the SBC will not attempt to elicit sexual partners or risk behaviors but will refer to DIS to investigate if the client describes risky behavior with at-risk partners. The SBC will also inform the client that a DIS will contact them in the near future to assist in partner notification and to provide education on HIV risk reduction.

Training:

All SBCs have received training on field work, substance abuse and mental health, and resistance/barriers to care. The following specific trainings must be completed by SBCs: CDC's *Introduction to Sexually Transmitted Disease Intervention* (2 weeks), *HIV Prevention Counseling* (3 days), *NC HIV Interviewing and Partner Notification* (1 week), *Cluster Intervention* (2 days) and *STDMIS 3.1* (1 day computer program course).

In addition, each SBC is trained in Anti-Retroviral Treatment and Access to Services (ARTAS), which is an evidence-based, individual-level, multi-session, time-limited intervention with the goal of linking recently-diagnosed persons to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology.⁶ SBCM is a model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the bridge counselor. Specifically, the ARTAS core elements include:

- Build an effective, working relationship between the Linkage Coordinator (SBC) and each client
- Focus on the client's strengths by:
 - Conducting a strengths-based assessment
 - Encouraging each client to identify and use his/her strengths, abilities, and skills to link to medical care and accomplish other goals.
- Facilitate the client's ability to:
 - Identify and pursue his/her own goals
 - Develop a step-by-step plan to accomplish those goals using the ARTAS Session Plan (This is not a required component of the SBC Program, although the SBCs should use the ARTAS paperwork at their discretion)
- Maintain a client-driven approach by:
 - Conducting between one and five structured sessions with each client (The SBC Program does not mandate minimum or maximum in-person sessions)
 - Conducting active, community-based case management by meeting each client in his/her environment and outside the office, whenever possible
 - Coordinating and linking each client to available community resources, both formal (e.g., housing agencies, food banks) and informal (e.g., friends, support groups, spiritual groups) based on each client's needs
 - Advocating on each client's behalf, as needed, to link him/her to medical care and/or other needed services⁷

The North Carolina State Bridge Counselors try to adhere to the ARTAS core elements as much as possible. However, the program does not depend on full ARTAS implementation nor is this expected to occur. The SBCs are asked to incorporate the components of ARTAS that are relevant to strengths-based work with out-of-care clients.

To schedule ARTAS training on-site, a request must be made through the state health department to the CDC/Danya International. A minimum of 10 participants must be available to attend the three-day training. For more information on ARTAS training visit:

<https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/ARTAS.aspx>.

Pre-Implementation Activities

The SBC linkage program underwent five PDSA cycles between each of the three learning sessions held in years 1 and 2 of the NC-LINK project. The first cycle developed and implemented the SBC process standards; the second cycle tested and modified the SBC Patient Information Form to use in the field; the third cycle modified the ARTAS process and implemented it in two regions; the fourth cycle tested the referral process from the regional site using the retention protocol, and the fifth cycle tested the CAREWare referral strategy for the retention protocol intervention.

An SBC workgroup was also developed in Year 2 with representatives from the NC Department of Health and Human Services, Duke, UNC, and the SBCs. The workgroup developed a set of process standards (see Appendix F) for the SBCs to follow. These standards were then revised to expand on the referral process for newly-diagnosed HIV-infected patients and priority groups for lost-to-care patients. These revisions were reviewed and edited by the SBC team before being implemented in the PDSA cycle.

Additionally, significant efforts were dedicated to establishing relationships between the SBCs and the clinics/regions and their designated retention staff. During the initial years of the project, many conversations were held between NC-LINK consulting partners, clinic staff and the SBCs to build this relationship and to plan for effective collaboration. The development of the retention protocol during the retention PDSA cycles also aided in increasing the transparency of the roles of the retention staff versus the roles of the SBCs. Additionally, delineating the roles of the SBCs and DIS helped the clinics understand the SBC as a different position with whom they could effectively partner and for different purposes than the DIS. The SBCs were also encouraged to attend regional meetings and meet face-to-face with the retention staff.

Lessons Learned:

The State Bridge Counselor intervention revealed the following lessons learned:

- Differentiating the roles and responsibilities of the DIS and SBCs was very important.

It became apparent early on in the pilot intervention that the role of the DIS and the role of the SBC served different purposes and that this difference needed to be delineated and emphasized. Initially, the SBCs were viewed as DIS officers and the clinics didn't trust that the SBCs would be able to do anything differently than the

clinics were in locating clients. The DIS were viewed as serving a more punitive role in identifying partners and issuing control violations whereas the SBC needed to be a more supporting role, building a relationship of trust with the patient to get them re-engaged in care. Differentiating between the two roles required many discussions and a great deal of stakeholder input. Overall job training on the difference between DIS and SBC, creating job descriptions specifically for SBCs, and creating standardized policies and procedures for SBCs were identified as helping to distinguish the two roles from one other.

- Developing a retention protocol and improving communication between SBCs and retention staff was critical

Developing the retention protocol and the process standards for the SBCs were necessary to help define the roles of the retention staff versus that of the SBCs and the different activities each would be doing to help locate and reengage clients. It was also outlined in the SBC protocol that each SBC should meet with retention staff to review the clinic's internal policies and procedures for record searches and locating clients who are out of care, which improved relationships between the clinics and the SBCs and helped avoid duplication of work.

- CAREWare emerged as the best communication tool between the SBCs and the retention staff

Early in the pilot intervention, there was much discussion about the best communication method for referring patients to the SBCs and it became apparent that paper, faxes, in-person communication were not sustainable or time-efficient. The transition to using CAREWare created the potential for more long-term sustainability as it was a system already in place and being used by the clinics and agencies across the state. It also reduced the time and high burden of paperwork in tracking clients for the SBCs and increased data-sharing and communication among providers around the state. The transition period also highlighted the importance of having a consistent data system throughout the intervention, as well as the importance of providing quality training to those using CAREWare in order to capture data consistently and correctly.

Conclusion

In North Carolina and nationally, PLWH need increased access to and retention in care. The NC-LINK *Systems Linkages* project has created a more coordinated system of linkages along the HIV continuum of care and increased communication among local and state HIV providers. The project addressed each level of the continuum and bridged care gaps through clinic-based testing of friends and family of HIV-infected patients, improved capacity of regional and clinic-based retention staff to retain HIV-infected individuals in care and re-engage those who are out-of-care, and State Bridge Counselors who rapidly link newly-diagnosed HIV patients into care and reengage patients who are out of care. Although each site will have different requirements, the lessons learned and information provided in this manual will aid others in replication of such programs. As such, this project has important public health findings and the potential for significant results if implemented in other settings.

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Appendix

APPENDIX A: Standard Operating Procedures for Testing in Clinic

Purpose: *To provide point of care rapid HIV testing for high risk visitors accompanying HIV infected patients at the Infectious Disease Specialty Clinic*

Required Reading: *All Infectious Diseases Providers and Staff*

Procedure:

2.1 Program Overview

- Individuals who accompany an HIV-infected patient to their clinic appointment will have the opportunity to receive free and confidential rapid HIV testing at the clinic. Testing will only be available to individuals who come in with a patient; walk-in testing will not be available.
- These individuals will be made aware of HIV testing through flyers in the exam rooms and discussions with medical providers and support staff in the clinic.
- If an individual desires HIV testing services, they will be directed to one of the Infectious Disease support staff in the clinic (i.e. Patient Navigator, Social Worker, Study Coordinator, and other trained staff) for a pre-test interview.
- The individual does not need to be registered in the EMR for this visit as it is free of charge. Documentation of the encounter will occur through the use of medical institution and local Health Department of Health Off-Site Testing forms (See attached **Appendices** for referenced forms/documents). The encounter and test results will also be logged in a secure file to be kept by Infectious Diseases for record keeping purposes.

3.1 Testing Management and Key Contacts

- **Program Oversight and Coordination:**
 - The HIV Medical Director will be the responsible Physician and site Manager for the testing program. This program will have CLIA certificate coverage from the main campus certificate holder. The HIV Coordinator and the Clinical Quality Administrator will share the responsibility for the management of this program. These responsibilities include:
 - Ensure all testers receive proficiency training in the test procedures by qualified trainers from the local Department of Health or their designee and additional refresher courses are provided as needed.
 - Ensure testers receive competency testing at start of testing after initial training and annually which will be documented in the tester's departmental employee file. Competency testing will include performance of a test on a blind specimen and observation of test administration by either the HIV Coordinator or the Clinical Quality Administrator.
 - Ensure all documentation of testing encounter is collected and housed in secure storage in the clinic.
 - Overseeing that test kit controls are done. The running of controls will be done routinely according to the manufacturer's instructions (see **OraQuick® Package Insert document**). Controls will be run when a new test kit lot is opened, when a new shipment is received with a different lot number, when a new tester begins testing for the first time, and if the temperature

goes out of range in the storage area (35-80°F). Documentation of controls will be maintained in the control log (See **Controls Log Spreadsheet**).

- Maintain adequate supplies of testing equipment are available at all times
- The test kits will be stored and maintained according to the manufacturer's instructions. Temperature will be monitored daily and recorded in the test kit storage area. Temperature logs are maintained by the Infectious Diseases Clinical Trials Unit (See **Sample temp Log**).
- **Test Device Information:** This program will utilize the OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test for rapid HIV testing and oral fluid will be the specimen collected. Test kits and other necessary materials for the program will be provided by the local Department of Health (see example of **Memorandum of Understanding**). Should additional supplies be needed, the HIV/STI Prevention Supervisor of the local Department of Health should be notified at 336-703-3181.
- **Documentation of Testing:** All tests done will be logged in a spreadsheet using the client's initials and last 4 digits of their social security number as an ID number. The spreadsheet will have the date of testing, tester name, lot number and expiration date of the test kit, test start time and end time, result, and confirmatory test plan if applicable (See **Testing Log Spreadsheet**).
- **Blood Specimen Information:** Should a blood specimen need to be drawn to be sent to the state lab, the tester should call 336-703-3212 or 336-703-3213 for pickup by the testing coordinators at the local Department of Health. Specimens can be refrigerated up to 24 hours before pickup by the local Department of Health.

4.1 Pre-test Interview

- The staff assigned to conduct the testing will begin with a pre-test interview in a confidential location to complete necessary pretest paperwork. This includes:
 - Review and completion of Consent for Rapid HIV Testing (**Rapid HIV Testing Consent Form**)
 - Data Collection for the **Interim Rapid Testing Form** – Sections 1 and 2 (state Health Department required form)
 - Completion of the **Acute HIV Infection Screening Form**
- Acute HIV Screening will be handled by the following process:
 - Should a client test “positive” for potential acute HIV infection based on screening criteria on the Acute HIV Infection Screening Form, the client will be offered serologic testing which requires registration as a patient and potential charges for testing and the visit.
 - Should the client not wish to register and potentially incur charges, they will be offered a referral to a local health department for serologic testing, or rapid testing can be performed in the clinic with repeat HIV testing recommended, and abstinence or safe-sex emphasized until repeat testing is obtained.
- After the client has consented to testing and the tester has completed Sections 1 and 2 of the Interim Rapid Testing Form, the client will be provided a Client Copy of their consent form to keep and a copy of the OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test Frequently Asked Questions document within the consent package. The tester will assess the need for any further counseling and answer additional questions prior to administering the test.

5.1 Rapid Testing Process

- The HIV rapid test will be administered per the manufacturer's instructions (see **OraQuick® Training Guide**). The test device will be labeled in the presence of the patient with their initials.
- The client will be directed to the waiting room after the test is administered to wait for their results. Results are available after 20 minutes.

- The tester is responsible for immediately taking the oral swab for processing in the designated testing area. Once the test has resulted, they will recall the client for results discussion. The tester will provide the client with a result form to take with them once results are obtained (see ***HIV Rapid Test Results Form***).

6.1 Post Test Counseling and Follow Up

- **Indeterminate Results:** In the rare occasion that the test result come back as Indeterminate (i.e. cannot be interpreted), the client should be offered a repeat test. If a second test cannot warrant an interpretable result, the tester should notify the Clinical Quality Administrator or HIV Coordinator who will call the manufacturer to report the case. The tester should retain the original packaging of the defective test kit for reporting. The client will then be offered a blood draw which will be sent to the state lab and have it sent to the state lab via the Local Health Department pick up service for processing.
- **Negative Results:** Should the test come back as HIV negative, the tester is responsible for conducting post-test counseling on the interpretation of the results. The tester will recommend future testing (i.e. every 3 months, 6 months, 12 months, etc.) based on risk profile. The tester will also facilitate a risk reduction discussion tailored to the behaviors the client is engaging in. If there is reason to believe the client may be in the window period but did not test positive on the acute HIV infection screening tool, then the client should return in 3 months for retesting. This client can also opt to have a blood draw and have it sent to the state lab via the local Health Department pick up service for processing.
- **Preliminary Positive Results:** Should the test come back as preliminary positive for HIV, the tester must ask another certified tester to read the device for quality control. The tester will also inform the Clinic Attending or designee for that day of the situation. If the test is confirmed preliminary positive by two readings by two different testers, then the tester will bring the client back to the confidential location for the results discussion.
- **Confirmatory Testing Process:** There are two immediate confirmatory testing options: Register as a patient of medical institution (if not already in the EMR system) and do testing through the clinic lab or the HIV Coordinator or an available Study Coordinator will draw blood to be sent to the state lab via the Local Department of Health pick up service for processing. If the client chooses to do their confirmatory test as a new patient of the clinic, and they are uninsured, they will meet with the Financial Counselor to discuss the Ryan White program which they will be eligible for should the test come back confirmed HIV-infected.
 - A new patient appointment should be scheduled as soon as possible within 1-2 weeks if they completed confirmatory testing at the medical institution and 3 weeks if the confirmatory testing will be done through the state lab. The patient should be offered an appointment for no more than 7 days after the confirmatory test results will be available.
 - If they would like to follow up with another clinic for HIV care after the confirmatory test results come back and are confirmed positive, they will be provided with a list of available clinics in their area to self-refer to.
 - The tester must complete Page 2 of the Interim Rapid Testing form and finalize this form once the confirmatory test results are back. This form will be sent to the Local Department of Health. The HIV Coordinator will also complete a ***NC DHHS Confidential Communicable Disease Report*** for the new HIV case per state law. The HIV Coordinator will also contact the NC Disease Information Specialists (DIS) about the new case. The client will be informed that they will be contacted by DIS per state law.
- **Refusal of Immediate Confirmatory Testing:** Should the client refuse to do confirmatory testing, this will be noted on the Interim Rapid Testing form and sent to the local Department of Health per protocol. The client will be strongly encouraged to do confirmatory testing and will also be provided with a list of sites to obtain testing should they desire to after they leave the clinic (***Sites for HIV Testing Form***). They

will be counseled on the importance of abstinence or barrier protection use for all types of sexual encounters until they received their confirmatory testing results. The client's information will be provided to DIS as a positive rapid test result and decline of confirmatory testing by the HIV Coordinator. A request may be made to have DIS assist with connection to confirmatory test if needed.

- **Loss to Follow Up:** If the person being tested has a preliminary positive HIV rapid test and leaves the clinic before receiving results, the client will be contacted by clinic staff and recalled to clinic for notification of results. Negative results for clients who leave before the test has finished running can be provided over the phone and will only be done with a live caller (no voicemails) and after 2 client identifiers (name, date of birth) are verified. Counseling as appropriate to the client's risk profile should be administered. If the client cannot be recalled to clinic and the result was preliminary positive, the HIV Coordinator will utilize the DIS system for assistance with notifying the client of the need for confirmatory testing. If the client chose to do the confirmatory test at the medical institution but cannot be reached for those results, the HIV Coordinator will work with DIS to recall the client for results discussion and next steps.
- **Management of Distressed Clients:** If the person being tested is overly distressed about a test result (positive or negative), the test counselor will refer and facilitate entry into counseling services with the assistance of other staff members as needed. This includes meeting with the clinic social worker or onsite psychologist if available. In extreme circumstances, the Psychiatry department can be paged for a clinic-based consult per the judgment of the Attending or designee in clinic.

7.1 Review Period

- This procedure will be reviewed at a minimum every **3 years** with revisions made to the procedures as needed between review periods.

APPENDIX B: Memorandum of Understanding for Testing



MEMORANDUM OF AGREEMENT (MOA)

Between

**Forsyth County Department of Public Health - HIV/STI Outreach Section
And
Wake Forest University Baptist Medical Center (Infectious Diseases Specialty Clinic)**

This Memorandum of Agreement (MOA) is entered into by and between Forsyth County Department of Public Health on behalf of the HIV/STI Outreach Section and Wake Forest University Baptist Medical Center (WFUBMC) and its Infectious Diseases Specialty Clinic (IDSC) (hereinafter referred to as “Administrator”), for the purpose of establishing and maintaining a working relationship with FCDPH in the provision of rapid HIV counseling, testing, referral, and educational services. This MOA is subject to the provisions of all applicable Federal and State laws, regulations, policies and standards.

The Department Manager of the Forsyth County Department of Public Health is Marlon Hunter (Health Director). The contact person will be Jennifer Nall, HIV/STI Outreach Section Supervisor, 336-703-3181. WFUBMC’s contact person will be Aimee M. Wilkin, MD, MPH, IDSC Medical Director (336-716-8978, awilkin@wakehealth.edu), who will also provide medical direction and supervision of the Administrator’s clinic’s participation in this MOA.

The WFUBMC contact person agrees to:

- Ensure that all persons conducting rapid testing have satisfactorily completed training on the test procedure from the distributor, the State Laboratory of Public Health or other approved trainer and perform testing procedures according to product insert. Successful completion of this training will include passing a proficiency test on the use of the rapid test.
- Ensure that all persons conducting pre and post test HIV counseling with persons being rapid tested receive HIV CTR training that is approved by the North Carolina Department of Health and Human Services (DHHS).
- Draw whole blood on every such person with preliminary positive results and submit the whole blood specimen or plasma specimen for testing at an in-house laboratory, reference laboratory, or at the State Laboratory of Public Health via the FCDPH HIV/STI Outreach Section.
- Complete and submit Interim Rapid Test Forms on a monthly basis via Fed-Ex to the FCDPH HIV/STI Outreach Section Supervisor.
- Ensure that test kits and controls are used in a timely manner and do not expire. Notify FCDPH HIV/STI Outreach Section Supervisor of any issues with test kits and controls.
- Collaborate with the FCDPH HIV/STI Outreach Section Supervisor for the purposes of establishing site procedures, paperwork/specimen collection requirements, and scheduling.

- Evaluate their rapid testing program on a yearly basis. This evaluation should focus on implementation of the rapid test program and outcome measures.

The FCDPH agrees to:

- Provide rapid test kits and controls to Aimee Wilkin of WFUBMC IDSC as needed and as available to FCDPH by DHHS. Should DHHS not make these kits available, FCDPH is under no obligation to continue distributing test kits to the Administrator.
- Provide Interim Rapid Test Forms to Aimee Wilkin of WFUBMC IDSC as needed and as available to FCDPH by DHHS.

It is further understood, that all activities under this MOA will be conducted in accordance with Title VI, Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 to assure that no persons, solely on the grounds of race, color, age, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity covered by this MOA.

The parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and each party warrants that its employees, agents and students providing the services herunder have received adequate training in HIPAA.

Each party is responsible for the acts and omissions of its own employees, students, and agents.

This MOA may be terminated by either party upon 30 days' written notice or immediately upon notice for cause. The scope and terms of this MOA may be amended in writing and signed by both parties. Such changes shall be incorporated herein as a written amendment to this MOA. Facsimile or electronic (e.g. pdf) versions of this Agreement shall have the same legal effect as originals, and all of which, when fully executed, shall constitute one and the same instrument.

This MOA shall begin on February 11, 2013 and end on February 10, 2015.

Forsyth Co. Dept. of Public Health

Wake Forest University Baptist Medical Center

BY: _____

BY: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

Read and agree to abide by:

By: _____

Name: Aimee M. Wilkin, MD, MPH

Title: IDSC Medical Director

HIV ANTIBODY TEST CONSENT FORM

RISKS:

I am aware that the following are possible risks for contracting HIV:

- HIV is spread through specific contact with blood, semen, vaginal secretions, and breast milk of an infected person.
- Sexual contact, including oral, vaginal and anal intercourse.
- Contact with infected blood including sharing needles for drugs, tattoos, and body piercings.
- Contact with infected blood due to health care accidents, and rarely through transfusions of blood products.
- Mother-to-child HIV transmission can occur through childbirth and breastfeeding by an infected mother to her baby.

PREVENTION AND RISK REDUCTION:

I am aware that HIV can be prevented in the following ways:

- Not engaging in any sexual activity is the only 100% effective way to prevent the *sexual* contraction of HIV. (Abstinence)
- When used consistently and correctly, latex or polyurethane condoms for oral, vaginal and anal intercourse can significantly reduce the risk of contracting HIV.
- Limit the number of your sexual partners. The more people you have sex with, the greater your risk of contracting HIV.
- Establish a healthy dialogue between you and your partner(s) concerning knowledge of HIV status and other Sexually Transmitted Diseases.
- Before you have sex, be sure that neither you nor your partner(s) have HIV by getting an accurate HIV test.
- Drugs and alcohol can alter your decision-making process. Abstaining from drugs and alcohol can help prevent risky behaviors from occurring.
- Never share needles.

TESTING:

I understand the following facts about HIV antibody testing:

- This test is looking for HIV antibodies (your body's reaction to the virus) and not the virus itself. Antibodies can take up to 3 months to develop.
- If I have had a risk in the last 3 months, a negative result may not be completely accurate. I may have been infected with the virus, but my body has not yet made antibodies.
- Therefore, I understand that I need to be tested 3 months after my last risk in order to for that HIV antibody test to be accurate.
- My test results will be kept confidential except for disclosures described in this Section.
- The results or record of this visit will not be kept in my medical record.
- The record of this visit will be provided to Forsyth County Department of Health, which will also be advised of positive results.
- IF my rapid test is positive, I will need to attain a confirmatory blood test.
- IF my confirmatory test result is positive, my name will be reported to the State Health Department, and I will be provided a counselor.

Alternatively, I am aware that I can have a blood test for HIV at other locations such as the following:

SITES FOR HIV TESTING

Forsyth County Department of Public Health
Clinic 2 - FREE HIV testing & STD exam
799 Highland Avenue
Winston Salem NC 27101
Phone: 336-703-3100

POSSE (Prevent Ongoing Spread of STDs Everywhere)
Various Community Sites
FREE HIV, Syphilis, Gonorrhea & Chlamydia testing
Phone: 336-703-3212 or 336-703-3213
www.POSSEhealth.org

Community Care Center
FREE HIV, Syphilis, Gonorrhea & Chlamydia testing
2135 New Walkertown Road
Winston Salem NC 27101
Phone: 336-723-6722

Guilford County Health Department - Greensboro
STD Clinic - FREE HIV testing & STD exam
1100 Wendover Avenue
Greensboro NC
Phone: 336-641-3245

Guilford County Health Department - High Point
STD Clinic - FREE HIV testing & STD exam
501 East Green Drive
High Point NC
Phone: 336-641-3245

Davidson County Health Department
STD Clinic - FREE HIV testing & STD exam
915 Greensboro St
Lexington NC 27292
Phone: 336-242-2510

Davie County Health Department
STD Clinic - FREE HIV testing & STD exam
210 Hospital Street
Mocksville, NC 27028
Phone: (336) 753-6750

OraQuick Advance Rapid HIV-1/2 Antibody Test Frequently Asked Questions

How does the OraQuick Advance HIV Rapid Test work?

OraQuick Advance tests for the presence of antibodies to HIV in bodily fluids. HIV antibodies are present in human oral fluids when a person is infected with HIV. An oral fluid sample will be collected on a test device. Your counselor will instruct you how to collect this sample and can provide your test result after a minimum time of 20 minutes.

How accurate is OraQuick Advance compared to the blood HIV test?

OraQuick Advance has been proven to be more than 99% accurate for detecting HIV antibodies. OraQuick is equally as accurate as conventional blood tests in detecting non-acute HIV infection. The *sensitivity* of a test is the **probability that the test is positive among people who are HIV positive**. The *specificity* of a test is the **probability that the test will be negative among people who are HIV negative**. Below are the sensitivities and specificities for each test:

<i>OraQuick Advance:</i>	Sensitivity: 99.3%	Specificity: 99.8%
<i>Blood Test (ELISA and Western Blot):</i>	Sensitivity: 99.9%	Specificity: 99.9%

What is the window period? What does this mean in terms of my test result?

The OraQuick Advance Rapid HIV-1/2 Antibody Test detects antibodies to HIV, not the virus itself. Antibodies are factors that are produced by the body to fight infections. Antibodies take time to form. The test will not be positive until enough antibodies are present in the blood for the test to find them. Different people take different amounts of time to develop antibodies after being infected. Some people will develop antibodies very quickly while others will take a longer time. *This time period between when a person is actually infected with HIV and when antibodies to HIV can be detected in the test is called the **window period**.* Nearly everyone who is infected with HIV (99%) will have antibodies detected by 3 months after infection. Your counselor will help you determine what your window period is and whether or not your test result is likely to be accurate based on the window period. **The Window Period is the same for OraQuick and the conventional ELISA Blood Test.**

OraQuick Advance tests for HIV-1 and HIV-2. What's the difference?

There are two types of HIV: HIV-1 and HIV-2. Both types are transmitted by sexual contact, through blood, and from mother to child, and they appear to cause clinically indistinguishable AIDS. However, it seems that HIV-2 is less easily transmitted, and the period between initial infection and illness is longer in the case of HIV-2. Worldwide, the predominant virus is HIV-1, and generally when people refer to HIV without specifying the type of virus they will be referring to HIV-1. The relatively uncommon HIV-2 type is concentrated in West Africa and is rarely found elsewhere.

What does an indeterminate test result mean?

An indeterminate test result is NOT an indicator of a positive HIV result. An indeterminate test result means that there was a problem running the test, either related to the specimen collected or to the OraQuick Advance test device. When this occurs, the test should be repeated with a new sample and testing device.

What should I know about false positive results?

False positive screening results, on the rare occasions they occur, may result from biological variations in the way a blood sample responds to a test, human laboratory errors, or health conditions such as hemophilia, autoimmune disorders, and alcohol-related hepatitis. Because false positive results can occur, **a confirmatory test is always necessary to conclude that HIV antibodies are present and to make a diagnosis of HIV infection.**

HIV Antibody Test Consent Signature Page

I have read and understood this information, and have been given the opportunity to ask questions about HIV antibody testing and about this consent form.

I hereby give permission to be confidentially tested for HIV.

Signature of Client

Date

Signature of Witness

Date

CLIENT INFORMATION:

This information is kept confidential, If for any reason you are unable to receive your results today we will need to contact you.

Name:

First Middle Initial Last

Address:

City: _____ State: _____ Zip: _____

Phone : (_____) _____ _____ Home/Work/Cell (circle one)

Phone : (_____) _____ _____ Home/Work/Cell (circle one)

Phone : (_____) _____ _____ Home/Work/Cell (circle one)

Last Four Digits of SSN: ____ _ or N/A

APPENDIX D: NC Department of Health Form

Office Use Only

Interim Rapid Testing Form Continued

Section 4 Confirmatory Testing

A. Confirmatory Testing State Lab? CTS Form Number

Date of Confirmatory Test / /
M M / D D / C C Y Y

If Not State Lab, Laboratory Used for Confirmatory Test

If Not Tested, Why?
 Client Declined
 Other

Confirmatory Test Results

EIA Test Result Positive Negative Indeterminate Unsatisfactory

Western Blot Result Positive Negative Indeterminate Unsatisfactory

RNA Test Result Positive Negative Indeterminate Unsatisfactory

Date Confirmatory Test Results Received / /
M M / D D / C C Y Y

For Confirmatory Western Blot Results

P17 <input type="checkbox"/> Yes <input type="checkbox"/> No	P24 <input type="checkbox"/> Yes <input type="checkbox"/> No	P31 <input type="checkbox"/> Yes <input type="checkbox"/> No	P51 <input type="checkbox"/> Yes <input type="checkbox"/> No	P55 <input type="checkbox"/> Yes <input type="checkbox"/> No	P66 <input type="checkbox"/> Yes <input type="checkbox"/> No	gp41 <input type="checkbox"/> Yes <input type="checkbox"/> No	gp160 <input type="checkbox"/> Yes <input type="checkbox"/> No
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B. Repeat Confirmatory Testing State Lab? CTS Form Number

Date of Repeat Test / /
M M / D D / C C Y Y

If Not State Lab, Laboratory Used for Repeat Confirmatory Test

If Repeat Test Not Performed, Why?
 Client Declined
 Other

Repeat Confirmatory Test Results

EIA Test Result Positive Negative Indeterminate Unsatisfactory

Western Blot Result Positive Negative Indeterminate Unsatisfactory

RNA Test Result Positive Negative Indeterminate Unsatisfactory

Date Repeat Confirmatory Test Results Received / /
M M / D D / C C Y Y

For Confirmatory Western Blot Results

P17 <input type="checkbox"/> Yes <input type="checkbox"/> No	P24 <input type="checkbox"/> Yes <input type="checkbox"/> No	P31 <input type="checkbox"/> Yes <input type="checkbox"/> No	P51 <input type="checkbox"/> Yes <input type="checkbox"/> No	P55 <input type="checkbox"/> Yes <input type="checkbox"/> No	P66 <input type="checkbox"/> Yes <input type="checkbox"/> No	gp41 <input type="checkbox"/> Yes <input type="checkbox"/> No	gp160 <input type="checkbox"/> Yes <input type="checkbox"/> No
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Section 5 Postive Tests: Patient Referrals

For Confirmed Positive Tests

Date Client Referred for Partner Counseling and Referral Services (PCRS) / /
M M / D D / C C Y Y

Date Client Referred for Care Services / /
M M / D D / C C Y Y

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. Follow the sample letters and numbers as closely as possible.

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	0			



APPENDIX E: Acute HIV Assessment

Acute HIV Infection Screening

Assessment for Acute HIV Infection in Pre-test Counseling

Pre-test counseling will include an assessment for symptoms compatible with acute retroviral syndrome in the prior 4 weeks. If clinical criteria are met, serologic HIV antibody testing (with reflex pooling for HIV RNA testing) should be recommended as the preferred testing method to diagnose acute HIV infection. The client should be notified that serologic testing requires registration as a clinic patient and fees for testing and the clinic visit. If the client declines, rapid testing can be performed with repeat HIV testing recommended, and abstinence or safe-sex emphasized until repeat testing is obtained.

Clinical criteria for suspicion of acute HIV infection

Serological HIV antibody testing (plus reflex pooling for HIV RNA testing) should be recommended as the preferred HIV test if **all** of the following criteria have been met within the preceding 4 weeks:

- HIV risk exposure defined as one of the following:
 - Unprotected oral, vaginal or anal sex with a known HIV positive person, an anonymous partner, or a partner of unknown HIV status.

OR

- Needle-sharing with intravenous drug use.
- Fever for ≥ 4 days
- At least one of the following signs for ≥ 4 days
 - Oral or mouth ulcers or sores
 - Swollen glands (lymph nodes) in the neck, armpits or groin area
 - Sore throat
 - Rash
 - Sores or lesions on the genitals (penis, scrota, labia, vagina)

APPENDIX F: State Bridge Counselor Process Standards

A. Client Management Objectives

- Increase the number of HIV-infected persons in care by linking newly diagnosed HIV- infected persons with an HIV care provider.
- Assist in the entry or re-engagement of HIV-infected persons who are not in care.
- Receive referrals from state Disease Intervention Specialists (DIS), and conduct activities to link HIV-infected persons to HIV care.
- Provide and accept referrals from the Regional Networks of Care (RNOC), Retention Staff, clinics, and providers for newly diagnosed HIV-infected persons or patients who are lost-to-care.
- Work in collaboration with RNOC services by:
 - Developing communication links and coordinating activities with regional local care providers who serve individuals with HIV/AIDS care needs (such as funded networks, non-funded hospitals, and community health centers, etc.)
 - Knowing the community agencies involved in care networks and how they operate
 - Clarifying SBC and Retention Staff roles within assigned regions
 - Attending the HIV Care Network meetings
- Assist the RNOC by attempting to get individuals who have been lost-to-care back into care through bridge counseling services. Attempt to locate or assist with the location of hard to find clients for RNOC providers and Retention Staff.
- Assess the need for medical and supportive services and arrange for patient to be linked to services as needed.
- Educate HIV-infected clients regarding sexually transmitted diseases (STDs), hepatitis B & C, tuberculosis risk factors and screening.
- Disseminate information regarding the availability of HIV testing, bridging, and care services throughout the assigned region.
- Maintain a working knowledge of local health and social services.
- Immediately report (within 24 hours) any HIV-infected clients who are turned away from services within the network of care to the AIDS Care Program and State HIV/STD Director's office.

B. REFERRAL and LINKAGE for Newly Diagnosed HIV-infected Clients

- a. All newly diagnosed HIV-infected clients reported to the Regional DIS office (new infections and previous infections newly reported in NC) will be referred to the SBC to ensure that they have made their initial clinic visit (from the DIS referral) or are subsequently seen by a prescribing provider within 60 days of the appointment date.
- b. The SBC does not need a signed release of information to follow a client.
- c. Alternatively, newly diagnosed HIV-infected clients may be referred by DIS to the medical or support services provider after the client provides a signed release of information.
- d. The SBC will consult with the service provider to determine if transportation assistance is needed.
- e. The timeframe for initiating contact attempts to locate new referrals is as follows:
 - i. Out of care—within 72 hours of receipt of referral
 - ii. Pregnant out of care—within 24 hours

Every newly reported case will be tracked by the SBC until attendance at the first medical visit with a prescribing provider is confirmed. The SBC should contact the client directly to determine if the visit was attended. If the client cannot be reached, the SBC can call the clinic to confirm whether the appointment was attended and to determine if a follow-up appointment is scheduled. If the client did not attend the appointment, the SBC will attempt to contact the client to address what prevented him/her from attending the appointment. Attendance confirmation should be documented in electronic databases, thereby minimizing duplicate efforts to contact the client and/or provider's office. The SBC will close the case after two weeks if they are unable to contact the patient.

C. Procedures for Linking to Care:

NEW HIV CASES AND PREVIOUS POSITIVES

1. DIS attempt to link new and previous HIV Cases to care immediately.
 - a. After Original Interview (OI) and/or when an initial appointment has been made for the client, the DIS enters appointment information in the Referrals Package in NC EDSS.
 - i. If appointment date is known, they should check the box for "track the details of this appointment" and enter the date and all other known details.
 - ii. If the appointment date is not known but the provider is known, the DIS should enter all known details.
 - iii. If the client has been referred to the RNOC or another case manager to assist with appointments, the DIS should enter a referral for HIV Case Management in the Referrals Package of NC EDSS and include all known details.
 - iv. The DIS should then go into the Bridge Counselor Package in NC EDSS to assign the case to the State Bridge Counselor in their region and select the status of the case at the time of assignment.
 - v. If the DIS is unable to make initial appointments for the patient, they still must assign the new HIV case to the Bridge Counselor in NC EDSS.
 - vi. If the DIS forgets to do this step, there is a workflow in NC EDSS that will 'catch' these cases. Currently this is the G.08.10 workflow. It will include New HIV cases that have not been assigned to the Bridge Counselor within 14 days of diagnosis. The Regional Supervisors are responsible for monitoring this work flow.
2. State Bridge Counselors follow up on New Cases
 - b. Use NC EDSS Workflows to keep track of cases
Note: Filter by REGION to see cases that are assigned to you. Start with 'Medical Appointments to Verify by Bridge Counselor'. This workflow will include any cases assigned to the SBC that also have medical appointments (with dates) listed in the referral package.
 - i. The BC can make phone calls, use CAREWare or otherwise verify attendance at appointment. Once attendance (or non-attendance) is verified, the SBC can complete the referral on the Referral Package. This action will bring the case out of the 'Medical Appointments' workflow.
 - ii. The BC then should go the BC Package, update all notes and submit to Supervisor for approval.
 - iii. Next move to the 'Bridge Counselor Events: Review Incomplete' workflow. This will include all cases assigned to the SBC in the region that have not been closed in the Bridge Counselor Package. Some of these may appear in other workflows as well (e.g. they may be in the Appointments workflow described above). Once the SBC checks the box for "Review Complete" and submits to

- Supervisor for approval, the case will come out of this workflow.
- iv. If SBC was able to verify attendance at an appropriate medical appointment, the case can be closed in the BC Package and in the Referrals Package (if it has not already been closed).
- v. If the patient did not attend the appointment or does not have one, the SBC may need to work to engage the patient. The SBC can enter their contact attempts in the BC Package and should enter any medical appointments in the Referral Package. Information about appointments that is found from another source (e.g. CAREWare) should be noted in the Referrals Package. It would be helpful to also note the source of the information in the notes field.
- vi. Completed Cases need to be submitted to the Supervisor for review. If the SBC forgets to do this, there is a workflow that will 'catch' these cases. This is currently the G.08.20 workflow. There are also work flows to show which cases are currently being reviewed by the supervisor and also for when the supervisor wants additional follow-up from SBC. Currently, these workflows are G.08.30 and G.08.50 respectively.

Note: PREVIOUS HIV cases that have been assigned to the SBC for re- engagement in care will also be in this workflow. The process for these will be discussed below.

PREVIOUS HIV CASES (Re-Engage in Care)

The SBC will be asked to assist in getting previously diagnosed HIV cases into care.

1. HIV Cases that require re-engagement need to be assigned to the SBC in the Bridge Counseling (BC) Package in NC EDSS.

- a. If a DIS or other NC EDSS user is requesting the re-engagement assistance, they can go into the BC Package and assign it to the SBC there. It will then appear in the BC Review Incomplete workflow.
- b. If the SBC receives notification about a case from an outside source (RNOC, medical provider, etc.), the SBC will need to go into NC EDSS and assign the case to themselves.
 - i. NOTE: if the SBC is asked to re-engage a case and it turns out that the patient is not actually in NC EDSS yet, the SBC will need to involve the Surveillance Coordinator and/or Supervisor to get the case appropriately reported and DIS original interview if needed.

2. Case Completion in NC EDSS

- a. As described above for NEW HIV Cases, the SBC needs to ensure that the patient attends a medical care appointment. This should be done by talking directly with the patient. If the SBC is unable to contact the patient, they should call the clinic; check NC EDSS for CAREWare lab entries to determine if the patient kept their clinic appointment.
 - i. Contact attempts can be documented in the BC Package in NC EDSS.
 - ii. Appointments should be documented in the Referrals Package.
 - iii. Completed cases should be sent to the Supervisor for approval.
- b. All Bridge Counseling (BC) workflows apply to re-engage cases with the exception of the new cases >14 days.

NOTE: the BC Package in NC EDSS is only designed to track the activities of the State DIS Bridge Counselors (SBCs). If another person is going to work with the patient for re- engagement (HIV Case Manager, Regional Network of Care, County Bridge Counselor, etc.), this needs to be documented as a Referral for HIV Case Management Services in the Referrals Package in NC EDSS. All new military cases will be referred to the SBC for review. In a military diagnosis, a notification is automatically sent to the client's command center and an appointment is scheduled for care. The SBC does not need to

link these cases into care, but should document in the BC Package that the referral is a military case and submit for closure.

REFERRALS BETWEEN SBCs

1. Submitting a referral to another region:
 - a. Assign the client's record to the outgoing SBC in the BC package in NC EDSS (including any notes/documentation)
 - b. Under the Investigation Trail in the Administrative Package, "Add New" and follow the same steps for Region to Region transfers outlined in your NC EDSS Manual and Business Policies/Rules (Note that your reason for assignment/reassignment would be LHD (Region) to LHD (Region) Transfer).
 - c. Add client to CAREWare and create a referral under the Referrals Tab to the outgoing SBC (Instructions are included in the CAREWare process steps in the SBC Operations Manual).

Note: Keep in mind that the SBC will ONLY use the INVESTIGATION TRAIL when the EVENT is moving to another region. (For example, the client's address was originally in Guilford County (Region 3), however the client has now moved/relocated to Cumberland County (Region 5)). If there is no relocation involved, continue to use only steps (a) and (c).

D. Referral and Re-Entry for HIV-infected Persons Lost-to-Care

- a. Each SBC will meet with the RNOC provider beforehand to understand internal policies and procedures for record searches and locating clients who have been lost-to-care prior to referral to the SBC. SBCs are encouraged to attend their RNOC quarterly meetings.
 - b. The referral from the care providers will be provided, at a minimum, through monthly confidential phone calls/confidential fax/CAREWare (select sites) or face-to-face meetings with the SBC.
 - c. The following groups will be prioritized by the SBCs upon referral from the RNOCs and be sent to one of the special populations State Bridge Counselors:
 - i. Pregnant women
 - ii. Post-incarceration patients
 - d. Other patients to prioritize are those with low CD4 counts and high viral loads.
- After receiving a referral, the SBC determines the patient's care status with the following steps:
 1. The SBC searches NC EDSS and state-wide CAREWare for any evidence that the patient is in care at another agency.
 2. If there is any evidence of recent testing or doctor's visits in NC EDSS or CAREWare, the SBC will confirm that the patient is in care with that provider if the provider is located within the SBC's geographic region. If not, the SBC will contact the SBC who covers the area the agency is located in to confirm the person's care status. Ensure that the provider is an ID practitioner, not an urgent care or ED provider.
 3. If the patient is confirmed to be in care at another provider's office, the SBC updates the referring agency of the change in medical provider within 4 weeks via CAREWare.
 4. Appointments should be entered in NC EDSS. The case can then be assigned in the BC Package and submitted to the Supervisor for approval.
 5. If there is no evidence that the person is in care anywhere else, the SBC will prepare the person's info for the field.
 6. If the patient is found to be in another region, the current SBC will assign the

case to the SBC who will receive the referral in the BC Package and in CAREWare (which will be described in the CW section). Once the new SBC has updated their attempts in the BC Package and submitted for closure, the referring SBC will then update the referring provider of the status and submit their section in the BC Package for Supervisor's approval.

- The SBC will follow the Record Search and Field Work Guide (below) to locate the client.
- Once a patient is found, the SBC inquires as to what caused them to fall out of care (i.e.- transportation, loss of insurance, etc.) and offers opportunities to overcome these obstacles to care.
 1. Contact attempts should be noted in the BC Package in NC EDSS.
 2. If the patient is willing to be re-engaged in care, an appointment is set. Information on the appointment should be entered in the Referrals Package in NC EDSS.
 3. If the patient refuses to go back to care, the SBC asks why the patient refuses to go back to care and attempts to address those issues. If the patient is still resistant, the SBC informs the referral source of the patient's refusal and updates all attempts made in the BC package.
- After the patient attends the medical visit (with a prescribing provider), the SBC will follow-up with a phone call to the patient to determine if a follow-up appointment has been made and to address any barriers to remaining in care. If the SBC is unable to contact the patient, they will confirm using CAREWare or lab data that the patient kept the medical appointment and scheduled a follow-up appointment.

When the appointment has been attended, the appointment should be closed in the Referrals Package and the case should be closed and submitted to the Supervisor in the BC Package of NC EDSS. The case is also closed in CAREWare.

E. Record Searches and Field Work

- a. SBC resources to determine care status will include any state data resources, including but not limited to: CAREWare, NC EDSS, ADAP, and Medicaid if applicable.
- b. Record searches will be done within current databases prior to going to the field with follow-up efforts. For clients previously contacted by DIS, SBC will consult with them before secondary visits are made.
- c. All standard locating resources (e.g., telephone book, cross directory, closed ERF's, clinic medical records, internet databases, etc.,) will be consulted prior to any field work.
- d. The specific procedures to be followed in preparation for field work are:
 1. SBC further readies the person's info for the field by record searching NC EDSS and the internet (i.e. 411.com, NC court calendar, NC voter registration, Facebook, Google, NC DOC, etc.) for additional locating info.
 2. Within one business day of receiving the referral, the SBC begins the field work by calling any available phone numbers (the patient's and emergency contacts) and/or visits the last known address following standard DIS field follow up protocol (i.e. three field visits at different times of day, phone calls at different times of day, etc.).

F. Communication and Client Sessions

- a. The client may be contacted using various methods including telephone, phone calls, home visits, client work locations, etc. Work location should be used as last resort. Emails and text messages are possible options with the client's permission.
- b. Personalized, sealed, and previously approved standard DIS referrals may be left for a client

only after determining that a client is not home and every effort has been made to verify the residence.

- c. No message, referral or letter may be mailed to a client except under extraordinary circumstances and must be previously approved by a supervisor.
- d. Interviews and client sessions will be conducted in person or over the phone.
- e. Before beginning an interview/counseling session, all reasonable effort must be completed by the SBC to confirm the client's identity and privacy of the conversation. SBCs will develop a positive rapport and learn as much as possible about the client to ensure the best possible response.
- f. The SBC will demonstrate professionalism including self-confidence, appropriate dress for the situation, competence and objectivity.
- g. The SBC will carry on all communications and activity with sensitivity and respect toward clients. A positive attitude is a key motivator for clients to remain in future care programs.
- h. The SBC will demonstrate appropriate concern for the client and work hard to establish rapport by displaying sensitivity to the clients' needs.
- i. The SBC will address the client's specific concerns and needs.
- j. Interpreter Services Policy will be followed ensuring the client has access to an interpretation service for their primary language. This activity will require pre-planning.
- k. All women should be asked about pregnancy status and referred for pregnancy testing as appropriate. Pregnant clients not in prenatal care are highest priority and should be referred to a LHD Maternal Care Coordinator.
- l. For the client who wants to approach client services on their own, the SBC will assist the patient in making a care plan for the patient to follow. Additionally, the SBC will follow the patient for two weeks to determine if the patient followed through with action items listed in their care plan.
- m. The SBC will recognize and respond appropriately to problem indicators by providing targeted motivators for the client to enter or re-enter care using strength-based counseling methods and techniques learned from ARTAS.

G. Partner Counseling and Referral Services (PCRS)

- a. SBC will work with HIV care providers and DIS to ensure that HIV-infected persons reporting risky behaviors receive additional PCRS.
- b. To maintain distinction between the DIS and the SBC, the SBC will not attempt to elicit sexual partners or risk behaviors but if the patient admits to risky behaviors with individuals who may be at risk for HIV infection, the SBC will refer to DIS to investigate. The SBC will also inform the client that a DIS will contact them in the near future to assist in partner notification and to provide education on HIV risk reduction.
- c. The Special Populations SBCs working with post-incarcerated clients may at times work with referred partners who are aware of their partner's HIV status and at risk for contracting HIV. This contact is limited to the Special Populations/CAPUS SBCs.

H. Confidentiality

- a. All confidential information must be securely handled in compliance with the Section's rules and State Law. The SBC will adhere to all confidentiality rules and will explain these rules carefully to the client to maximize understanding.

I. Efficiency and Safety

- a. For the SBC, each day should begin with an efficient plan to conduct field visits in a way that minimizes travel time.
- b. The SBC will ensure that he/she can be reached by phone by colleagues in case of an emergency.
- c. For safety purposes, if the SBC is required to meet a client after normal work hours, prior approval may be required. The field supervisor should be contacted after the visit (usually by phone) to ensure the SBC's safety.
- d. If a client calls from out of town, the SBC will do the following:
 - i. Assure the caller's identity with SSN, DOB, physical description or other means as appropriate or necessary. The SBC will obtain the client's number and return the call immediately to that number.

J. Documentation

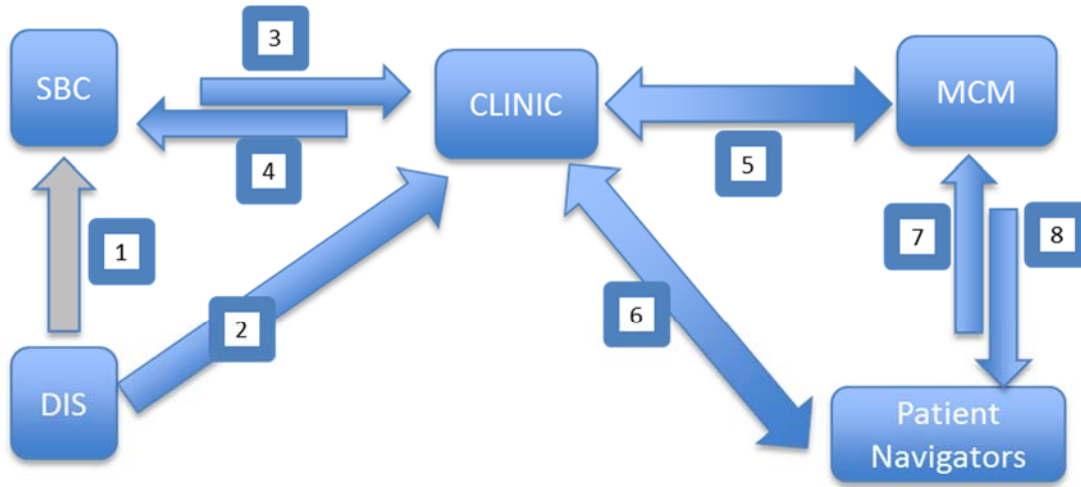
- a. SBC will document outreach efforts in NC EDSS and in CAREWare. *See CW Appendix P.* Attempts to contact the client will be documented as soon as possible after the activity has occurred in the BC Package. Documentation should include the date, the time, the purpose of the contact, a concise explanation of outcome and SBC's full name. Per Field Services policy, if a contact attempt is not documented, then it is considered not done.
- b. All completed and closed field records will be submitted for Supervisor review within 48 hours of closure.
- c. If field records remain closed for two months, all documents within the record should be shredded.
- d. The SBC will follow-up to ascertain if the re-engagement appointment was kept within 14 days of the initial appointment date. This can be done by looking at electronic medical records, lab data, and/or other data systems. The SBC may also confirm the appointment with clinic staff in some occasions.
- e. If the patient did not attend the re-engagement visit, the SBC should call the patient directly to find out why the patient missed the appointment and attempt to set another appointment. Contact attempts must be documented in the BC Package in NC EDSS.
- f. If the patient is unresponsive to multiple attempts to contact him/her after two weeks, the SBC closes the patient's field record and updates the referring agency. The case must also be closed in NC EDSS by completing the BC Package and submitting to the Supervisor for approval.

K. Transfer or Close-out

- a. Occasionally, field work reveals that a patient has moved out of state. Once this is confirmed, the SBC closes out the person's paperwork and informs the referring provider. The BC Package in NC EDSS should also be updated and the case submitted to the Supervisor for approval.
- b. When a lost to care patient is found to be incarcerated, the following steps occur:
 - i. If a person is in prison, the patient's paperwork is closed out after confirming that the patient is receiving HIV care services thru the NC DOC. This should be documented in both the Referrals Package and the BC Package in NC EDSS. The case should be closed and submitted to the Supervisor for approval. (There should not already be a Referrals Package open in Lost to Care clients)
 - ii. If the person is in jail, the RNOC is informed immediately as some RNOCs work with jails to re-engage HIV-infected individuals back into care. This should be documented in the Referrals Package as a referral for HIV Case Management and then closed out in the BC Package.

- c. When a person is suspected to have moved within the state of North Carolina but outside of the SBC's region, the following steps occur:
 - i. The SBC notifies the SBC covering the region by assigning the case and indicating there is an out-of-care patient in their area in the BC Package. The SBC may need to "share" the case in NC EDSS with the other region, depending on the view/update permissions that each SBC has.
 - ii. The new SBC working with the patient should make all appropriate updates to NC EDSS and close the Referrals and BC Package when they have sufficiently appropriate information. The case then needs to be submitted to the Supervisor for approval.

APPENDIX G: NC-LINK/CAPUS Flowchart



#	Referral	Description & Indication
1	DIS to SBC	REFERRAL: indirect thru NCEDSS ELIGIBLE: All newly diagnosed pts EXCLUSIONS: out of state who are transient and have refused NC care
2	DIS to Clinic	REFERRAL: direct handoff ELIGIBLE: All newly diagnosed pts EXCLUSIONS: refusal to accept care
3	SBC to Clinic	REFERRAL: direct handoff ELIGIBLE: All newly diagnosed pts w/ 1 st visit pending EXCLUSIONS: refusal of care
4	Clinic to SBC	REFERRAL: indirect thru CAREWare ELIGIBLE: 1 st visit patients; Field work need EXCLUSIONS: LTC who can be contacted by clinic or MCM; pt refusal
5	Clinic to MCM/SW	REFERRAL: collaborative care ELIGIBLE: need for specific support services, esp MH, SU tx EXCLUSIONS: pt refusal
6	Clinic to PN	REFERRAL: collaborative care ELIGIBLE: minority, EXCLUSIONS: significant untreated mental health, SU d/o; pt refusal
7	PN to MCM/SW	REFERRAL: direct handoff or collaborative care ELIGIBLE: Needs for specific services, mental health, addiction tx EXCLUSIONS: pt refusal
8	MCM/SW TO PN	REFERRAL: direct handoff or collaborative care ELIGIBLE: minority EXCLUSIONS: Caucasian, severe untreated mental illness, SUD; pt refusal

APPENDIX H: STAT Cases

ACUTE HIV and PREGNANT FEMALES BRIDGING TO CARE

Pregnant Females

1. The Bridging to Care process for HIV (+) Pregnant Female will start during the initial DIS contact/interview.
 - a. DIS will complete the Referral Package in NC EDSS and assign client to a State Bridge Counselor (SBC) or Special Population Bridge Counselor (SPBC) within 24 hours of OI.
2. Medical care opportunities will be presented at the initial interview and scheduled by DIS
3. For women who accept care referral:
 - a. DIS will provide transportation to initial medical appointment.
 - 1) When necessary, DIS will elicit assistance from other FSU staff, for initial transportation needs of AHI clients
 - b. DIS will provide information about the SBC/SPBC and briefly describe their role.
 - c. DIS will inform the client that the SBC/SPBC will contact them after their medical appointment.
 - 1) SBC/SPBC will follow-up with pregnant HIV-INFECTED women or their Case Manager/Social Worker on a monthly basis to ensure the client remains in care and on meds, until she delivers.

Acute HIV Cases (STAT and Community Acute)

Acute HIV Cases are defined as people diagnosed as STAT from the NC SLPH or any community HIV diagnosed case where there is documentation of a negative or indeterminate HIV test within 30 days of a positive test or detectable HIV-1 RNA.

1. The Bridging to Care process for the Acute HIV Index (AHI) Case will start during the initial DIS contact/interview.
 - a. DIS will complete the Referral Package in NC EDSS and assign client to SBC or SPBC within 24 hours of OI.
2. The following opportunities for medical evaluation/consultation will be presented to the AHI case at the initial interview and scheduled by DIS:
 - a. UNC
 - b. ID Specialist located near the client's residence
 - c. ID specialist listed in the established STAT network of care.
3. For clients who accept care referral:
 - a. DIS will provide transportation to the initial medical appointment.
 - 1) When necessary, DIS will elicit assistance from other FSU staff, for initial transportation needs of AHI clients
 - b. DIS will provide information about the SBC and briefly describe the SBC's role.
 - 1) DIS will inform the client that the SBC will contact them after their medical

appointment.

- a) The SBC will contact all AHI cases within 24 hours of first care appointment.

4. For clients who refuse the initial medical referral:

- a. DIS will follow up with the individual within 72 hours of the initial contact to attempt to re-engage them to care.

- 1) If a client continues to refuse care, the DIS will provide information about the SBC and briefly describe the SBC's role
- 2) The DIS will then assign the case over to the SBC
 - a) The SBCs are responsible for completing the referral package in NC EDSS (including collecting all necessary information from the provider).
 - b) SBC will provide any relevant information to DIS for STAT calls.
- 3) The DIS will also provide the client with the phone number (1-866-883- 1836) and the information postcard for One Call.

APPENDIX I: SBC General Job Description

**PROPOSED NEW
PUBLIC HEALTH DISEASE CONTROL SPECIALIST II
BRIDGE COUNSELOR
SALARY GRADE 69**

I. A. Primary Purpose of Organizational Unit

The Epidemiology Section of the Division of Public Health (DPH) is responsible for reducing morbidity and mortality resulting from communicable, occupational and environmental diseases and conditions. It is also responsible for investigating environmental risks for the population of the state of North Carolina. Additional responsibilities include investigation and surveillance activities; enforcement of control measures; coordination of activities with local health departments, private practitioners, and others; and the collection, review and analysis of data related to each of the section program areas.

The Communicable Disease Branch is a subordinate agency of the Epidemiology Section. The goal of the Communicable Disease Branch is to conduct surveillance activities for communicable diseases, including HIV and other STDs, and other diseases reportable under NC law, and to protect the health of the citizens of North Carolina through prevention and control of those diseases. Branch staff review case report data and assist local health directors with appropriate control measures to help prevent transmission. The Branch is also responsible for monitoring health data from hospital emergency departments, poison center calls, ambulance data and other sources to detect diseases that may result from terrorism, and to provide situational awareness during outbreaks and natural or other man-made disasters. This is accomplished through the examination of raw data submitted in near real time fashion with the collaboration of public health partners. In addition, the AIDS care component of the Branch ensures that HIV/AIDS-infected individuals are able to access a continuum of care services, including: case management, medical and dental care, complicated and expensive medications regimens, housing and a full range of ancillary services. The Branch currently has over 165 employees and operates with a highly-diverse, complex budget in excess of one hundred million dollars.

The organizational structure consists of five diverse and unique units: Operations, Epidemiology and Surveillance, Medical Consultation, HIV/STD Prevention and Care, and Field Services. The Field Service Unit currently has 5 regional field service offices and 2 satellite offices; DIS II/Bridge Counselors are part of this unit. All staff in this unit is trained to assist in disease investigation.

B. Primary Purposes of Position

The DIS II/Bridge Counselor position is a regionally-based, specialized position that provides active care referral for people living with HIV/AIDS, Hepatitis and other diseases and/or conditions that

require specialized care and treatment. Specifically the position assists HIV-infected clients in accessing or re-engaging in care if they have dropped out.

This position will network with the regional HIV care programs including county/state DIS, private providers and case managers while also serving as a link between HIV diagnosed individuals and the regional HIV care network.

C. Work Schedule

The routine work schedule is Monday through Friday, 8:00 AM to 5:00 PM. However, this position is very demanding and time consuming requiring the incumbent to work flexible hours to comply with the Unit, Branch, Section, Division, and Department needs and patient schedules. This may on occasion include evening and some weekend hours away from the office and without supervision, frequently in conditions considered a safety risk. Periodic assignment away from the duty station may require extended hours away from home.

D. Change in Responsibilities or Organizational Relationships

The Branch and its programs have grown significantly in size and scope in recent years, requiring greater effort and attention to internal collaboration and cooperation. As program initiatives have expanded to include work with community-based organizations, Bridge Counselors now have greater and broader responsibilities for liaison and consultation. Bridge counseling activities provide culturally competent, non-judgmental, client centered referral and linkage to care services with full participation of clients as appropriate in the acquisition of HIV care. The dramatic and regular increase in HIV/AIDS knowledge and treatments and other communicable diseases expands the responsibility of DIS II/Bridge Counselor to stay current when directly providing information to patients and their partners, consulting with agencies, and offering training. Over the past several years the position has required entering into dangerous environments due to the proliferation of illicit drug and gun use that is associated with the individuals and neighborhoods most in need of disease intervention. The increase in drug use has also expanded the work done in correctional and substance abuse treatment facilities.

II. A. Description of Responsibilities and Duties

The Public Health Disease Intervention Specialist II/ Bridge Counselor position is critical to controlling the spread of HIV infection and sexually transmitted diseases in North Carolina. This position has regional responsibility for referrals to care, linkage to care, liaison and consultation activities. The position requires an advanced level of current disease knowledge and professional expertise for consultation and rapid disease intervention, and understanding of HIV provider care networks. Employee must establish and maintain effective working relationships with patients and their partners, the medical community, the public and community-based organizations. The employee must communicate at an appropriate level, incorporating cultural sensitivity with both professionals and clients of all ages, races, ethnic origins, and from varied socio-economic backgrounds. They must be skilled in active listening, empathizing and must remain non-

judgmental while discussing personally and socially sensitive issues with clients. DIS II/Bridge Counselor must be willing and able to work independently in potentially dangerous locations and situations that frequently are not handicapped accessible. The work has a direct personal impact on the health of North Carolina citizens. The engagement activities of the DIS II/ Bridge Counselor may reduce healthcare costs by reducing the number of persons who become infected and by referring infected clients into coordinated medical care that can limit costly complications.

In addition, this position is also expected to perform work as needed relating to other communicable diseases as well as public health preparedness (i.e. all hazards/events that place North Carolinians at risk) if an urgent situation arises.

1. Direct Disease Intervention: 50%

The DIS II/Bridge Counselor ensures rapid disease intervention by acting to ensure that HIV-infected clients are engaged and retained in care. The duties are to:

- a. Attempt to locate known HIV-infected clients who have fallen out of care and reengaging them into medical care.
- b. Follow established protocols to determine if a client is out of care (including missed office visits, unsuppressed or out of date viral loads) and act accordingly.
- c. Follow up with clients after initial medical visits to assure on-going engagement in care and assist in overcoming any barriers to care.
- d. Document in NC EDSS and CAREWare, as appropriate, the actions taken to engage clients in care.
- e. Communicate Branch goals and objectives and ensure their achievement through effective coaching and training of DIS I's and in the development of Bridge Counseling procedures.
- f. Assist the Regional Supervisor with the preparation and analysis of narrative and statistical reports.
- g. Resolve problematic or slowed intervention activities.
- h. Diligently protect the confidentiality and privacy of all clients by the ways in which oversight, field work, record keeping and all communications are conducted consistent with law, Division, Section/Branch and Unit policy and protocol.
- i. Monitor, collect and maintain (paper and computer) surveillance data for HIV/AIDS/STDs within the region.

2. Consultation and Technical Assistance: 10%

DIS II/Bridge Counselor provide consultation and technical assistance to the health care and human services professional community directly and as higher level back up for DIS I. They provide:

- a. Consultation to clinicians and other health care providers on CDC treatment guidelines, practice guidelines and patient assessment protocols. The employee will need a thorough working knowledge of medical terminology and STD disease processes.
- b. Consultation to local health directors on federal, state and local public health laws and regulations.
- c. Consultation to local health department personnel and other health care providers on interviewing and counseling techniques.
- d. Liaison to hospitals, correctional centers, military installations, migrant programs, HIV Care Networks, substance abuse treatment programs, community-based organizations, and HIV prevention planning groups and non-traditional counseling and testing sites.
- e. Consultation regarding the maintenance of patient records and surveillance data processing.
- f. Collaboration with other HIV/STD Prevention and Care units and programs on continuing policies and projects.

3. Epidemiology Support: 10%

Employee carries out some of the same office-based intervention duties as the DIS I in the course of routine oversight and management of the intervention activities of the regional office. These are noted below. In addition DIS II/Bridge Counselor may carry out the field activities of a DIS I when it is necessary to assist with difficult or problematic situations, to model skills during training, and to assure rapid intervention during staff shortages or during a response to a disease outbreak (R.I.O.T.) in another region.

- a. Ensure treatment and follow-up of HIV/STD clients at county health departments and/or with private health care providers.
- b. Monitor HIV/AIDS case reports from local health departments and private health care providers for accuracy and completeness.

4. Prevention Activities: 25%

The DIS II/Bridge Counselor aids in the prevention of disease with each client encounter. Behavior-based and client-centered counseling are part of the linkage and reengagement into care processes. The DIS II/Bridge Counselor will:

- a. Facilitate collaborative relationships with HIV/STD clinicians, local health departments, correctional facilities, substance abuse treatment programs, and community-based organizations.
- b. Assure clients make their first HIV medical appointment. Serve as client's point of contact between time of diagnosis and first HIV medical appointment.
- c. Work to ensure that clients who are HIV-infected and are "out of care" with a medical provider are re-engaged in care.

- d. Maintain a working knowledge of local health and social services responsible for the care of HIV infected clients.
- e. Make appropriate referrals to HIV care and social services after a client needs assessment.
- f. Document and track initial HIV care visits and follow up with HIV-infected clients who have missed their initial HIV care appointments.
- g. Participate in Rapid Intervention Outreach Teams (R.I.O.T.), Health, Education, and Risk-reduction Teams (HEART) and other outreach activities as needed.

5. Administrative Duties: 5%

DIS II/ Bridge Counselor coordinate services with local health care providers and DIS to provide the most efficient means of engagement in care, disease intervention, and consultation. The employee solves problems involving daily operations. DIS II/ Bridge Counselor must be well-organized and self-disciplined with regard to meeting deadlines, record keeping, writing case reports, filing, and overall case management activities. The DIS II/Bridge Counselor will assist the regional secretary with phone coverage and other administrative duties as assigned during staff shortages to assure on-going availability to providers and clients and support services for rapid disease intervention.

B. Other Position Characteristics

1. Accuracy Required in Work

Precision and accuracy are required in: HIV/AIDS and STD case management and all related intervention and prevention activities; consultation and technical assistance; analysis, interpretation of survey and surveillance data; interpretation of program and/or personnel policies, guidance and protocols for federal and/or state employees; collection or elicitation of partner information during interviews; location of patients and partners in the field including the use of maps and directories; documentation of all activities, drawing of patient blood; and prevention and risk reduction planning.

2. Consequences of Error

The work performed affects individual citizens of North Carolina and the public health at large in a variety of significant ways. Errors in case management, interviewing or partner notification could result in additional persons infected with STDs or HIV and the concomitant health, economic and mortality outcomes. Errors in field locating could result in clients' worsening health or in transmission to partners. Failure to follow policy, guidance and/or protocol may result in: violations of client confidentiality, unnecessary safety risk for staff and others, additional exposures or infections, and misuse or abuse of state equipment and supplies. Errors in documentation could result in inappropriate or unnecessary treatments, limited capability to enforce disease control measures, and additional and unnecessary work. Errors in consultation could result in

other providers facing many of the same consequences as those of staff members noted above.

3. Instructions Provided to Employee

The employee is given significant independent responsibility in carrying out program activities on a day to day basis, especially in those duties spent out of the office without direct supervision. Regular consultation, direction, coaching and training is provided by the Bridge Counselor Supervisor. The Regional Supervisor will also provide guidance in handling controversial or sensitive matters and in resolving problems related to program operation or administrative matters. Most instructions and coaching situations are oral instructions with follow-up discussions as appropriate; however formal reviews or personnel actions will be accompanied by written performance observations and expectations.

DIS II/Bridge counselor must have completed an extensive training program that includes: study and testing on CDC's employee development informational modules, observation of experienced staff in all phases of work, completion of: CDC's *Introduction to Sexually Transmitted Disease Intervention* (2 weeks), *HIV Prevention Counseling* (3 days), *NC HIV Interviewing and Partner Notification* (1 week), *Cluster Intervention* (2 days) and *STDMIS 3.1* (1 day computer program course), and employee work observed and supported by a supervisor. DIS II/ Bridge Counselor complete supervisory training offered either by CDC or by State Personnel. In addition, regular staff meetings include case analysis study and other informational and skill building components.

4. Guides, Regulations, Policies, and References Used by Employee

The employee in this position uses and is governed by many laws, rules, guides, regulations, policies, and references. These include *STD Treatment Guidelines*, *HIV Prevention Counseling Standards and Guidelines*, *Partner Counseling and Referral Services Guidance*, *Quality Assurance Guidelines for Clinic Managers*, *STD Clinical Practice Guidelines* and *STD Employee Development Guide*. The employee utilizes North Carolina communicable disease laws (primarily G.S. 130A-133) and administrative code rules (primarily 15 A NCAC 19A.0100-.0211) in fulfilling his/her duties with clients and as a resource and guide in consultation and technical assistance. DIS refer to *The Physicians Desk Reference* for information on drugs, the *Control of Communicable Diseases in Man* for information on diseases and the appropriate treatment. Departmental, Division, Section and Branch policies on confidentiality, computer use, cell phone use, travel, and other topics provide parameters of employee work. DIS II/ Bridge Counselor use many references to aid in locating clients including phone books, city cross directories, and internet resources.

5. **Supervision Received by Employee**

Employee performance is reviewed through formal and informal meetings with the Bridge Counselor Supervisor; however the employee frequently acts with significant independent responsibility and judgment in consultation with professional providers and in client interactions. DIS II/Bridge Counselor receive coaching, oversight, support and mentoring from the Bridge Counselor Supervisor. Travel reports and time sheets are reviewed by the Bridge Counselor Supervisor. Indirect supervision by the Unit Head may also be received from time to time.

6. **Variety and Purpose of Personal Contacts**

The employee may interact with health care and other professionals including physicians, nurses, health directors, medical records staff, laboratory technicians, mental health and substance abuse counselors, corrections/law enforcement officers, outreach workers, agency directors, and clergy to provide consultation and technical assistance, to assure appropriate and timely patient treatment, and linkage to care. Client encounters are with persons from all social and economic classes, races, ages, neighborhoods, and occupations. Most of these clients are either infected with or exposed to STDs, HIV or have AIDS; some have tuberculosis, other communicable diseases and/or mental illness. Some clients are involved in illegal activities. Therefore, it is highly recommended that staff have up to date immunizations including Hepatitis due to being exposed to situations in the field and in clinics to people with communicable diseases. Hepatitis immunizations will be provided if staff do not have prior to position acceptance. The employee also has extensive personal contact with employees inside the Unit, Branch, Division and Department to facilitate internal coordination and cooperation. The employee interacts with the general public in public meetings and makes presentations on HIV infection and STDs at many of these meetings.

7. **Physical Effort**

The work is primarily cerebral. However, the employee does perform work that is mentally and physically tiring including (a) field visitations and audits, (b) counseling activities, (c) travel within assigned areas that may require driving long distances, (d) preparation of paperwork, (e) carrying audio-visual equipment.

8. **Work Environment and Conditions**

The employee works primarily in the office, but frequently in the field, including client homes, offices, local health departments, outdoor locations, and human services agencies. Office conditions are usually simple and functional. Some offices provide private offices and others have shared offices. Due to confidentiality issues employees work in cubicles unless the entire office area is limited to Unit personnel. Substantial travel is required to contact and counsel with clients, to provide technical assistance to

regional networks and to represent the program at meetings. Field activities take place in both urban and rural settings, often in economically depressed neighborhoods and/or where the crime rate is above average. In order to successfully locate clients, DIS II/ Bridge Counselor must visit sites ranging from street corners to homes, crack houses, business locations and to homeless shelters/camps. Many of these sites are located in remote locations requiring substantial travel.

9. Machines, Tools, Instruments, Equipment and Materials Use

Computers, calculators, cellular phones, pagers, copiers and fax machines are used extensively. The employee is required to drive his/her personal vehicle when conducting field investigations.

10. Visual Attention, Mental Concentration and Manipulative Skills

Attention to detail is required when preparing and reviewing paperwork, laboratory reports and statistical reports or when reading directives, maps, manuals, rules and regulations. Mental concentration is required during counseling procedures, consultation and case analysis. Significant intensive mental concentration is required of the employee during all client encounters. The work requires conversations with patients that may become confrontational even if handled with great skill by the employee. Thus the employee must be fully alert and attentive when encountering patients and professional health care providers.

11. Safety for Others

Maintaining confidentiality of all public health records and of all information concerning individuals with or at risk for HIV/STDs is crucial. Breaches of confidentiality may compromise the program's ability to obtain accurate, complete, and timely information. Failure to assure confidentiality in all aspects of the work can jeopardize the physical and emotional safety of clients and their partners. The employee is required to be prepared to use his/her personal vehicle to transport patients (and sometimes their young children) to and from providers. This service, if not carried out with extreme caution, could result in injury or even death to those being transported.

12. Dynamics of Work

HIV/STD consultation and epidemiological analysis and resulting actions have a direct economic and social impact on the health of North Carolina citizens. The knowledge of and methods for control and treatment of HIV and STDs are constantly changing and require frequent adjustments in operation and utilization of new techniques and technology. All of these conditions make this a complex and demanding position that must deal effectively with health care professionals, individuals affected by disease as well as the general public.

III. A. Knowledge, Skills, and Abilities

1. Ability to establish and maintain consulting relationships with health care and other human services professionals.
2. Thorough and current knowledge of HIV infection, AIDS, syphilis, gonorrhea, chlamydia and other sexually transmitted diseases, their symptoms, complications, prevention and epidemiology.
3. Skills in directing and scheduling office operations and activities of staff members.
4. Ability to make independent judgments consistent with training and protocol.
5. Knowledge of the principles and skills in the practice of disease investigation.
6. Skills in client interviewing, disease case management and client-centered counseling are strongly preferred.
7. Ability to establish rapport and effective communication with health care and other professionals, with clients, and with community members.
8. Excellent verbal and written communication skills.
9. Ability to interpret and apply federal, state, and local public health laws, rules, and regulations, which are applicable to sexually transmitted diseases and related issues.
10. Ability to express ideas clearly, concisely and sensitively in oral and written form.
11. Ability to plan and execute work in a timely manner.
12. Skills in basic computer programs including Windows© and word processing (preferably Word©) and in data entry. Ability to successfully develop, interact with and manage client data base.
13. Ability to synthesize many issues and factors into a comprehensive whole.
14. Ability to work successfully among culturally diverse populations.
15. Ability to work in high crime and highly sensitive communities.
16. Ability to make successful public presentations.
17. Must be aware of community based prevention and care resources and be able to develop positive internal and external relationships.

B. 1. Required Minimum Training

Graduation from a four-year college or university and two years of experience as a Public Health Disease Control Specialist, including one year in the same program area; OR an equivalent combination of training and experience in HIV disease intervention, bridge counseling, adherence counseling.

2. Additional Training/Experience

Graduation from a four year college or university in a health or human services related field and two years experience in public health investigation or disease prevention activities OR some college/university education in a health or human services related field and two years' experience in public health or disease prevention or adherence activities. Fluency in Spanish is highly desired. Consulting and counseling training experience is also highly desired.

3. Equivalent Training and Experience

Prefer one-year employment or training in disease intervention or public health related field specific to HIV and STD investigations in a field environment or an equivalent combination of the proceeding training and experience.

C. License or Certification Required by Statute or Regulation

A valid North Carolina driver's license is required.

APPENDIX J: Special Populations SBC Job Description

**PROPOSED NEW
PUBLIC HEALTH DISEASE CONTROL SPECIALIST II
BRIDGE COUNSELOR
SALARY GRADE 69**

I. A. Primary Purpose of Organizational Unit

The Epidemiology Section of the Division of Public Health (DPH) is responsible for reducing morbidity and mortality resulting from communicable, occupational and environmental diseases and conditions. It is also responsible for investigating environmental risks for the population of the state of North Carolina. Additional responsibilities include investigation and surveillance activities; enforcement of control measures; coordination of activities with local health departments, private practitioners, and others; and the collection, review and analysis of data related to each of the section program areas.

The Communicable Disease Branch is a subordinate agency of the Epidemiology Section. The goal of the Communicable Disease Branch is to conduct surveillance activities for communicable diseases, including HIV and other STDs, and other diseases reportable under NC law, and to protect the health of the citizens of North Carolina through prevention and control of those diseases. Branch staff review case report data and assist local health directors with appropriate control measures to help prevent transmission. The Branch is also responsible for monitoring health data from hospital emergency departments, poison center calls, ambulance data and other sources to detect diseases that may result from terrorism, and to provide situational awareness during outbreaks and natural or other man-made disasters. This is accomplished through the examination of raw data submitted in near real time fashion with the collaboration of public health partners. In addition, the AIDS care component of the Branch ensures that HIV/AIDS-infected individuals are able to access a continuum of care services, including: case management, medical and dental care, complicated and expensive medications regimens, housing and a full range of ancillary services. The Branch currently has over 165 employees and operates with a highly-diverse, complex budget in excess of one hundred million dollars.

The organizational structure consists of five diverse and unique units: Operations, Epidemiology and Surveillance, Medical Consultation, HIV/STD Prevention and Care, and Field Services. The Field Service Unit currently has 5 regional field service offices and 2 satellite offices; DIS II/Bridge Counselors are part of this unit. All staff in this unit is trained to assist in disease investigation.

B. Primary Purposes of Position

The DIS II/Bridge Counselor position is a regionally-based, specialized position that provides active care referral for people living with HIV/AIDS, Hepatitis and other diseases and/or conditions that require specialized care and treatment. Specifically the position assists HIV-infected clients in

accessing or re-engaging in care if they have dropped out. The primary focus of this position will be to target HIV-infected inmates upon release from incarceration their partners, and HIV-infected pregnant women.

This position networks with the regional HIV care programs including county/state DIS, private providers and case managers while also serving as a link between HIV diagnosed individuals and the regional HIV care network. Additionally, this position will also work very closely with jail and prison staff to identify and provide services, as needed, to HIV-infected inmates upon their release.

C. Work Schedule

The routine work schedule is Monday through Friday, 8:00 AM to 5:00 PM. However, this position is very demanding and time consuming requiring the incumbent to work flexible hours to comply with the Unit, Branch, Section, Division, and Department needs and patient schedules. This may on occasion include evening and some weekend hours away from the office and without supervision, frequently in conditions considered a safety risk. Periodic assignment away from the duty station may require extended hours away from home.

D. Change in Responsibilities or Organizational Relationships

The Branch and its programs have grown significantly in size and scope in recent years, requiring greater effort and attention to internal collaboration and cooperation. As program initiatives have expanded to include work with community-based organizations, Bridge Counselors now have greater and broader responsibilities for liaison and consultation. Bridge counseling activities provide culturally competent, non-judgmental, client centered referral and linkage to care services with full participation of clients as appropriate in the acquisition of HIV care. The dramatic and regular increase in HIV/AIDS knowledge and treatments and other communicable diseases expands the responsibility of DIS II/Bridge Counselor to stay current when directly providing information to patients and their partners, consulting with agencies, and offering training. Over the past several years the position has required entering into dangerous environments due to the proliferation of illicit drug and gun use that is associated with the individuals and neighborhoods most in need of disease intervention. The increase in drug use has also expanded the work done in correctional and substance abuse treatment facilities.

II. A. Description of Responsibilities and Duties

The Public Health Disease Intervention Specialist II/ Bridge Counselor position is critical to controlling the spread of HIV infection and sexually transmitted diseases in North Carolina. This position has regional responsibility for referrals to care, linkage to care, liaison and consultation activities. The position requires an advanced level of current disease knowledge and professional expertise for consultation and rapid disease intervention, and understanding of HIV provider care networks. Employee must establish and maintain effective working relationships with patients and their partners, the medical community, the public and community-based organizations. The

employee must communicate at an appropriate level, incorporating cultural sensitivity with both professionals and clients of all ages, races, ethnic origins, and from varied socio-economic backgrounds. They must be skilled in active listening, empathizing and must remain non-judgmental while discussing personally and socially sensitive issues with clients. DIS II/Bridge Counselor must be willing and able to work independently in potentially dangerous locations and situations that frequently are not handicapped accessible. The work has a direct personal impact on the health of North Carolina citizens. The engagement activities of the DIS II/ Bridge Counselor may reduce healthcare costs by reducing the number of persons who become infected and by referring infected clients into coordinated medical care that can limit costly complications.

In addition, this position is also expected to perform work as needed relating to other communicable diseases as well as public health preparedness (i.e. all hazards/events that place North Carolinians at risk) if an urgent situation arises.

1. Direct Disease Intervention: 40%

The DIS II/Bridge Counselor ensures rapid disease intervention by acting to ensure that HIV-infected clients are engaged and retained in care. The duties are to:

- a. Attempt to locate known HIV-infected clients who have fallen out of care and reengaging them into medical care.
- b. Follow established protocols to determine if a client is out of care (including missed office visits, unsuppressed or out of date viral loads) and act accordingly.
- c. Follow up with clients after initial medical visits to assure on-going engagement in care and assist in overcoming any barriers to care.
- d. Document in NC EDSS and CAREWare, as appropriate, the actions taken to engage clients in care.
- e. Communicate Branch goals and objectives and ensure their achievement through effective coaching and training of DIS in the development of Bridge Counseling procedures.
- f. Assist the Regional Supervisor with the preparation and analysis of narrative and statistical reports.
- g. Resolve problematic or slowed intervention activities.
- h. Diligently protect the confidentiality and privacy of all clients by the ways in which oversight, field work, record keeping and all communications are conducted consistent with law, Division, Section/Branch and Unit policy and protocol.
- i. Monitor, collect and maintain (paper and computer) surveillance data for HIV/AIDS/STDs within the region.

2. Consultation and Technical Assistance: 15%

DIS II/Bridge Counselor provide consultation and technical assistance to the health care and human services professional community directly and as higher level back up for DIS I. They provide:

- a. Consultation to clinicians and other health care providers on CDC treatment guidelines, practice guidelines and patient assessment protocols. The employee will need a thorough working knowledge of medical terminology and STD disease processes.
- b. Consultation to local health directors on federal, state and local public health laws and regulations.
- c. Consultation to local health department personnel and other health care providers on interviewing and counseling techniques.
- d. Liaison to hospitals, correctional centers, military installations, migrant programs, HIV Care Networks, substance abuse treatment programs, community-based organizations, and HIV prevention planning groups and non-traditional counseling and testing sites.
- e. Consultation regarding the maintenance of patient records and surveillance data processing.
- f. Collaboration with other HIV/STD Prevention and Care units and programs on continuing policies and projects.

3. Epidemiology Support: 20%

Employee carries out some of the same office-based intervention duties as the DIS I in the course of routine oversight and management of the intervention activities of the regional office. These are noted below. In addition DIS II/Bridge Counselor may carry out the field activities of a DIS I when it is necessary to assist with difficult or problematic situations, to model skills during training, and to assure rapid intervention during staff shortages or during a response to a disease outbreak (R.I.O.T.) in another region.

- a. Ensure treatment and follow-up of HIV/STD clients at county health departments and/or with private health care providers.
- b. Monitor HIV/AIDS case reports from local health departments and private health care providers for accuracy and completeness.
- c. Assist in identifying areas of high disease morbidity for screening, and plan and execute community assessment and outreach activities.

5. Prevention Activities: 15%

The DIS II/Bridge Counselor aids in the prevention of disease with each client encounter. Behavior-based and client-centered counseling are part of the interview and notification processes. The DIS II/Bridge Counselor will:

- a. Facilitate collaborative relationships with HIV/STD clinicians, local health departments, correctional facilities, substance abuse treatment programs, and community-based organizations.
- b. Assure clients make their first HIV medical appointment. Serve as client's point of contact between time of diagnosis and first HIV medical appointment.

- c. Work to ensure that clients who are HIV-infected and are “out of care” with a medical provider are re-engaged in care.
- d. Maintain a working knowledge of local health and social services responsible for the care of HIV infected clients.
- e. Make appropriate referrals to HIV care and social services after a client needs assessment.
- f. Document and track initial HIV care visits and follow up with HIV-infected clients who have missed their initial HIV care appointments.
- g. Participate in Rapid Intervention Outreach Teams (R.I.O.T.), Health, Education, and Risk-reduction Teams (HEART) and other outreach activities as needed.

5. Administrative Duties: 10%

DIS II/ Bridge Counselor coordinate services with local health care providers and DIS to provide the most efficient means of engagement in care, disease intervention, and consultation. The employee solves problems involving daily operations. DIS II/ Bridge Counselor must be well-organized and self-disciplined with regard to meeting deadlines, record keeping, writing case reports, filing, and overall case management activities. The DIS II/Bridge Counselor will assist the regional secretary with phone coverage and other administrative duties as assigned during staff shortages to assure on-going availability to providers and clients and support services for rapid disease intervention.

B. Other Position Characteristics

1. Accuracy Required in Work

Precision and accuracy are required in: HIV/AIDS and STD case management and all related intervention and prevention activities; consultation and technical assistance; analysis, interpretation of survey and surveillance data; interpretation of program and/or personnel policies, guidance and protocols for federal and/or state employees; collection or elicitation of partner information during interviews; location of patients and partners in the field including the use of maps and directories; documentation of all activities, drawing of patient blood; and prevention and risk reduction planning.

2. Consequences of Error

The work performed affects individual citizens of North Carolina and the public health at large in a variety of significant ways. Errors in case management, interviewing or partner notification could result in additional persons infected with STDs or HIV and the concomitant health, economic and mortality outcomes. Errors in field locating could result in clients’ worsening health or in transmission to partners. Failure to follow policy, guidance and/or protocol may result in: violations of client confidentiality, unnecessary safety risk for staff and others, additional exposures or infections, and misuse or abuse of state equipment and supplies. Errors in documentation could result in inappropriate or unnecessary treatments, limited capability to enforce disease control

measures, and additional and unnecessary work. Errors in consultation could result in other providers facing many of the same consequences as those of staff members noted above.

3. Instructions Provided to Employee

The employee is given significant independent responsibility in carrying out program activities on a day to day basis, especially in those duties spent out of the office without direct supervision. Regular consultation, direction, coaching and training is provided by the Bridge Counselor Supervisor. The Regional Supervisor will also provide guidance in handling controversial or sensitive matters and in resolving problems related to program operation or administrative matters. Most instructions and coaching situations are oral instructions with follow-up discussions as appropriate; however formal reviews or personnel actions will be accompanied by written performance observations and expectations.

DIS II/Bridge counselor must have completed an extensive training program that includes: study and testing on CDC's employee development informational modules, observation of experienced staff in all phases of work, completion of: CDC's *Introduction to Sexually Transmitted Disease Intervention* (2 weeks), *HIV Prevention Counseling* (3 days), *NC HIV Interviewing and Partner Notification* (1 week), *Cluster Intervention* (2 days) and *STDMIS 3.1* (1 day computer program course), and employee work observed and supported by a supervisor. DIS II/ Bridge Counselor complete supervisory training offered either by CDC or by State Personnel. In addition, regular staff meetings include case analysis study and other informational and skill building components.

4. Guides, Regulations, Policies, and References Used by Employee

The employee in this position uses and is governed by many laws, rules, guides, regulations, policies, and references. These include *STD Treatment Guidelines*, *HIV Prevention Counseling Standards and Guidelines*, *Partner Counseling and Referral Services Guidance*, *Quality Assurance Guidelines for Clinic Managers*, *STD Clinical Practice Guidelines* and *STD Employee Development Guide*. The employee utilizes North Carolina communicable disease laws (primarily G.S. 130A-133) and administrative code rules (primarily 15 A NCAC 19A.0100-.0211) in fulfilling his/her duties with clients and as a resource and guide in consultation and technical assistance. DIS refer to *The Physicians Desk Reference* for information on drugs, the *Control of Communicable Diseases in Man* for information on diseases and the appropriate treatment. Departmental, Division, Section and Branch policies on confidentiality, computer use, cell phone use, travel, and other topics provide parameters of employee work. DIS II/ Bridge Counselor use many references to aid in locating clients including phone books, city cross directories, and internet resources.

5. Supervision Received by Employee

Employee performance is reviewed through formal and informal meetings with the Bridge Counselor Supervisor; however the employee frequently acts with significant independent responsibility and judgment in consultation with professional providers and in client interactions. DIS II/Bridge Counselor receive coaching, oversight, support and mentoring from the Bridge Counselor Supervisor. Travel reports and time sheets are reviewed by the Bridge Counselor Supervisor. Indirect supervision by the Unit Head may also be received from time to time.

6. Variety and Purpose of Personal Contacts

The employee may interact with health care and other professionals including physicians, nurses, health directors, medical records staff, laboratory technicians, mental health and substance abuse counselors, corrections/law enforcement officers, outreach workers, agency directors, and clergy to provide consultation and technical assistance, to assure appropriate and timely patient treatment, and linkage to care. Client encounters are with persons from all social and economic classes, races, ages, neighborhoods, and occupations. Most of these clients are either infected with or exposed to STDs, HIV or have AIDS; some have tuberculosis, other communicable diseases and/or mental illness. Some clients are involved in illegal activities. Therefore, it is highly recommended that staff have up to date immunizations including Hepatitis due to being exposed to situations in the field and in clinics to people with communicable diseases. Hepatitis immunizations will be provided if staff do not have prior to position acceptance. The employee also has extensive personal contact with employees inside the Unit, Branch, Division and Department to facilitate internal coordination and cooperation. The employee interacts with the general public in public meetings and makes presentations on HIV infection and STDs at many of these meetings.

7. Physical Effort

The work is primarily cerebral. However, the employee does perform work that is mentally and physically tiring including (a) field visitations and audits, (b) counseling activities, (c) travel within assigned areas that may require driving long distances, (d) preparation of paperwork, (e) carrying audio-visual equipment.

8. Work Environment and Conditions

The employee works primarily in the office, but frequently in the field, including client homes, offices, local health departments, outdoor locations, and human services agencies. Office conditions are usually simple and functional. Some offices provide private offices and others have shared offices. Due to confidentiality issues employees work in cubicles unless the entire office area is limited to Unit personnel. Substantial travel is required to contact and counsel with clients, to provide technical assistance to

regional networks and to represent the program at meetings. Field activities take place in both urban and rural settings, often in economically depressed neighborhoods and/or where the crime rate is above average. In order to successfully locate clients, DIS II/ Bridge Counselor must visit sites ranging from street corners to homes, crack houses, business locations and to homeless shelters/camps. Many of these sites are located in remote locations requiring substantial travel.

9. Machines, Tools, Instruments, Equipment and Materials Use

Computers, calculators, cellular phones, pagers, copiers and fax machines are used extensively. The employee is required to drive his/her personal vehicle when conducting field investigations.

10. Visual Attention, Mental Concentration and Manipulative Skills

Attention to detail is required when preparing and reviewing paperwork, laboratory reports and statistical reports or when reading directives, maps, manuals, rules and regulations. Mental concentration is required during counseling procedures, consultation and case analysis. Significant intensive mental concentration is required of the employee during all client encounters. The work requires conversations with patients that may become confrontational even if handled with great skill by the employee. Thus the employee must be fully alert and attentive when encountering patients and professional health care providers.

11. Safety for Others

Maintaining confidentiality of all public health records and of all information concerning individuals with or at risk for HIV/STDs is crucial. Breaches of confidentiality may compromise the program's ability to obtain accurate, complete, and timely information. Failure to assure confidentiality in all aspects of the work can jeopardize the physical and emotional safety of clients and their partners. The employee is required to be prepared to use his/her personal vehicle to transport patients (and sometimes their young children) to and from providers. This service, if not carried out with extreme caution, could result in injury or even death to those being transported.

12. Dynamics of Work

HIV/STD consultation and epidemiological analysis and resulting actions have a direct economic and social impact on the health of North Carolina citizens. The knowledge of and methods for control and treatment of HIV and STDs are constantly changing and require frequent adjustments in operation and utilization of new techniques and technology. All of these conditions make this a complex and demanding position that must deal effectively with health care professionals, individuals affected by disease as well as the general public.

III. A. Knowledge, Skills, and Abilities

1. Ability to establish and maintain consulting relationships with health care and other human services professionals.
2. Thorough and current knowledge of HIV infection, AIDS, syphilis, gonorrhea, chlamydia and other sexually transmitted diseases, their symptoms, complications, prevention and epidemiology.
3. Skills in directing and scheduling office operations and activities of staff members.
4. Ability to make independent judgments consistent with training and protocol.
5. Knowledge of the principles and skills in the practice of disease investigation.
6. Skills in client interviewing, disease case management and client-centered counseling are strongly preferred.
7. Ability to establish rapport and effective communication with health care and other professionals, with clients, and with community members.
8. Excellent verbal and written communication skills.
9. Ability to interpret and apply federal, state, and local public health laws, rules, and regulations, which are applicable to sexually transmitted diseases and related issues.
10. Ability to express ideas clearly, concisely and sensitively in oral and written form.
11. Ability to plan and execute work in a timely manner.
12. Skills in basic computer programs including Windows© and word processing (preferably Word©) and in data entry. Ability to successfully develop, interact with and manage client data base.
13. Ability to synthesize many issues and factors into a comprehensive whole.
14. Ability to work successfully among culturally diverse populations.
15. Ability to work in high crime and highly sensitive communities.
16. Ability to make successful public presentations.
17. Must be aware of community based prevention and care resources and be able to develop positive internal and external relationships.

B. 1. Required Minimum Training

Graduation from a four-year college or university and two years of experience as a Public Health Disease Control Specialist, including one year in the same program area; OR an equivalent combination of training and experience in HIV disease intervention, bridge counseling, adherence counseling.

2. Additional Training/Experience

Graduation from a four year college or university in a health or human services related field and two years experience in public health investigation or disease prevention activities OR some college/university education in a health or human services related field and two years' experience in public health or disease prevention or adherence activities. Fluency in Spanish is highly desired. Consulting and counseling training experience is also highly desired.

3. Equivalent Training and Experience

Prefer one-year employment or training in disease intervention or public health related field specific to HIV and STD investigations in a field environment or an equivalent combination of the proceeding training and experience.

C. License or Certification Required by Statute or Regulation

A valid North Carolina driver's license is required.

APPENDIX K: CAREWare Instructions

A. Tracking your work in CAREWare:

1. Out-of-care referrals:

- a. The first step is to try to locate the client. All time and effort spent looking for the client should be tracked manually (on paper or some other method). When the client is located, the SBC should complete the fields on the NC-LINK tab. Then, all contact with the client or efforts made for the client to get them back into medical care are tracked in CAREWare by completion of *Bridge Counselor Service* entries. When the client has been successfully re-engaged in care by confirming that the client has attended a medical care appointment the SBC should complete a *Bridge Counseling Service Outcome* entry and follow the appropriate steps to close the record and the referral in CAREWare.
- b. In the situation where the SBC exhausts all resources and cannot locate the client, the steps are slightly different. All time and effort spent looking for the client should still be tracked manually (on paper or some other method). Once the SBC decides that they cannot locate the client, the SBC should complete the CW fields on the NC-LINK tab. Then, the SBC should complete a *Bridge Counseling Service Outcome* entry and follow the appropriate steps to close the record and the referral in CAREWare.
- c. If an out-of-care referral needs to be sent from one SBC to another because the client's last known address is out of the receiving SBC's region, the receiving SBC should enter the record in CAREWare then follow the instructions below to send the referral on to the appropriate SBC and close the record in the receiving SBC's domain.

2. DIS 1st appointment verification referrals:

- a. Upon receipt of a DIS referral to verify that a client is actively engaged in medical care, fill out all the appropriate fields on the NC-LINK tab. Then, when phone calls are made or Electronic Medical Records (EMRs) are reviewed, or whatever other methods are employed to verify that a client is in care, the SBC should complete a *Follow-Up* service entry. Upon verification that the client is engaged in medical care, the SBC should complete a *Bridge Counseling Service Outcome* and select *Verified that client is in care* for the 'Outcome of Bridge Counseling' field and follow the appropriate steps to close the record in CAREWare.
- b. If, upon completing the phone call or EMR review, etc. the SBC determines that the client DID NOT keep the 1st appointment or that the client requires SBC services to engage in care, the client should then be handled like an out-of-care referral. The SBC should complete the NC-LINK tab fields and then track all their efforts to get the client engaged in medical care with the completion of *Bridge Counselor Service* entries. When the client has been successfully re-engaged in care (confirming attendance to a medical care appointment) the SBC should complete a *Bridge Counseling Service Outcome* entry and follow the appropriate steps to close the record in CAREWare.

3. Jail/Prison Referrals:

Outreach Nurses will refer all released prison inmates by phone or secure fax to one SP SBC who will refer the patient to the appropriate SBC depending on the site of release.

B. SBC CAREWare Notes and FAQs

- Any client who is lost to care OR is out of care who requires intervention/contact of any type by the SBC MUST be entered into CAREWare for NC-LINK evaluation tracking purposes. This includes referrals from DIS/NC EDSS, phone call or fax referrals.
- **DO NOT** enter a *Bridge Counselor Service* in CAREWare if the only action you take on a client record is researching or looking for them and the client is never located. The amount of time spent researching or looking for a patient is tracked on the NC-LINK tab.
- After locating a client, SBCs must document a *Bridge Counselor Service* EVERY time a client contact or an attempt is made OR work is completed on a client's behalf (i.e. calling a clinic, arranging for transportation, etc.). This may require multiple *Bridge Counselor Service* entries on the same day. If the SBC *never* gets in contact with a client, there should NOT be any bridge counseling services entered. The only service entered for a client who was NOT located is a Bridge Counseling Service Outcome entry when the SBC is closing the referral to indicate the outcome of the SBC's efforts.
- After locating a client, Part B funded SBCs must enter whatever Part B sub-service(s) they are providing and then ALSO enter a *Bridge Counselor Service* EVERY time they make or attempt to have contact with a client OR do work on the client's behalf (i.e. calling a clinic, arranging for transportation, etc.). This could require multiple *Bridge Counselor Service* entries on the same day.
- Ctrl/W will toggle from the SBC domain to the central admin domain and back again.
- When finding a client in CW, the Shift * tab button will display all the records in the domain.
- The central admin domain may be used to research a new client to see if they are in care in some other CAREWare provider location of the state network.
- On the NC-LINK tab, complete all data fields, selecting the appropriate choices from the drop-down boxes. For the question "**TOTAL number of minutes spent looking for patient**" enter the sum (in minutes) of all the time you spent trying to locate the client from start to finish, whether the client was located or not.
- SBCs should enter the **NC EDSS ID** (also called the state case number) in the client ID field on the demographics tab in CAREWare.
 - In NC EDSS:
 - State Number does not always equal Event ID
 - State Number does not always equal Person ID
- To ensure that the correct State Number is being entered into the CAREWare "Client ID" field:
 - In NC EDSS, go to Administrative Question Package
 - Look under heading "CDC Reporting Information"
 - The third field down is "State Case Number"
 - State Case Number=StateNo=Client ID
 - Enter "State Case Number" in CAREWare "Client ID" field
- HIV/AIDS date should be verified in NC EDSS prior to entering it in CAREWare.
- CAREWare provides a number of choices for 'Enrollment Status' however, when closing out a SBC referral in CAREWare, please select the appropriate status from the following three choices ONLY:
 - **Referred or Discharged**
 - **Incarcerated**
 - **Relocated**

Possible SBC scenarios:

1. The SBC knows where the client lives; they have spoken in the past. The SBC drives to the client's home and no one is there. The SBC leaves a note for the client (does not include any revealing health information) and drives back to the office.
 - a. Enter a Bridge Counselor Service in CAREWare. Enter the SBC name, and number of minutes spent driving to and from the client's home in the **# of min for other pt-related activities NOT w/pt** field. No other data fields should be entered for this service.
 - b. Part B funded SBC's will also enter in a Part B sub service
2. The SBC makes contact with the client by phone. They spend 10 minutes talking about the need to meet and discuss the client's HIV status, etc. No barriers are discussed and no services are provided.
 - a. Enter a Bridge Counselor Service in CAREWare. Enter the SBC name, leave the "**# of min for other pt-related activities NOT w/pt**" field blank, select phone- for **Type of contact**, leave "**# of min providing strength-based counseling**", and "**# of min addressing barriers with patient**" fields blank, and 10 for **Total contact minutes**. DO NOT check any of the checkboxes indicating barriers addressed or services provided.

APPENDIX L: SBC CAREWare Process Steps

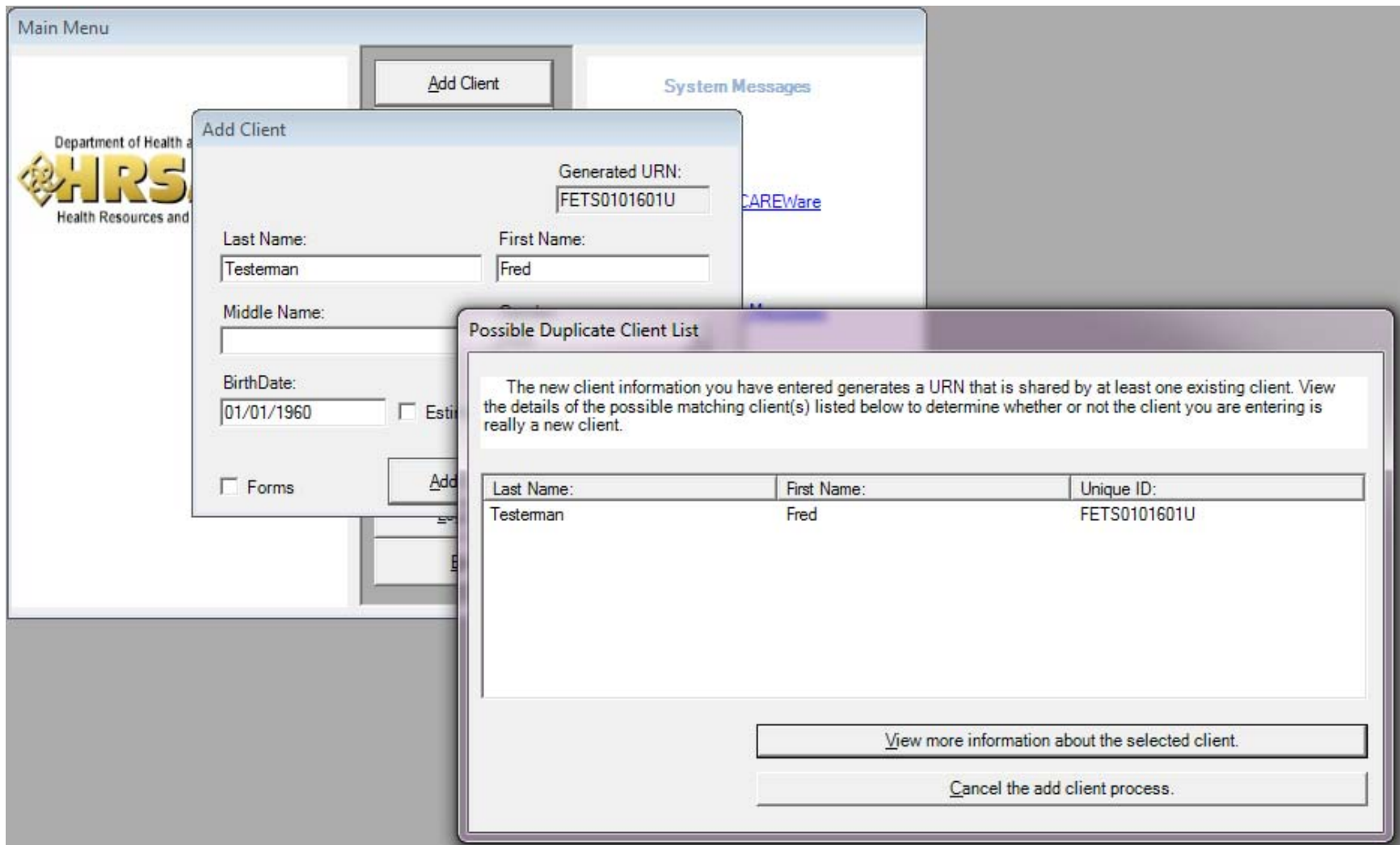
Any client that requires intervention/contact of any type by the SBC must be entered into CAREWare for NC-LINK evaluation tracking purposes. There are two ways to get the client record into CAREWare.

- For referrals received via NCEDSS, phone, or fax:
Client data is entered in CAREWare by the SBC to open the record, using the **Add Client** functionality.

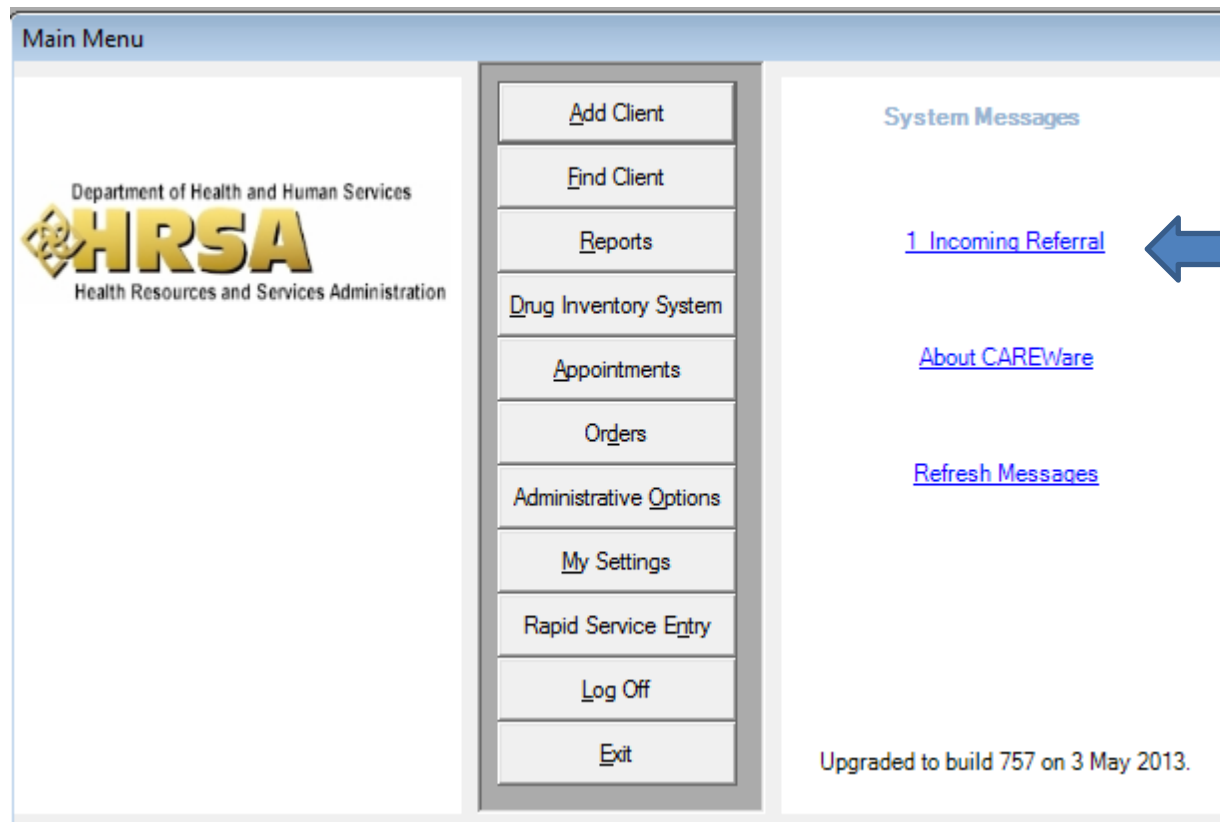
The screenshot displays the 'Add Client' dialog box within the CAREWare application's 'Main Menu'. A blue arrow points to the 'Add Client' button in the background. The dialog box contains the following fields and options:

- Generated URN:** FETS9999991U
- Last Name:** Testeman
- First Name:** Fred
- Middle Name:** (empty field)
- Gender:** Male (dropdown menu)
- BirthDate:** 01/01/1960
- Estimated?
- Forms

Buttons at the bottom of the dialog include 'Add Client' and 'Cancel'. The background interface shows the 'Main Menu' with 'Add Client', 'System Messages', 'CAREWare', 'Messages', and 'Exit' buttons, and the 'Department of Health and Human Resources' logo.



- For referrals received via the CAREWare electronic referral function:
An **Out of Care** referral is received via CAREWare. When the SBC logs into their CW domain they will see an **Incoming Referral** on the main menu screen. Accepting this referral will open the client record in their domain. In order to accept the referral it must be opened in the receiving SBC domain by double clicking on the client row in the pending referral list of incoming referrals.



- View of the Referrals tab on the client record that was received via a CAREWare referral:

Testerman, Fred Izza

[Appointments](#) | [Orders](#) | [Forms](#) | [Change Log](#) | [Client Report](#) | [Merge Client](#) | [Delete Client](#) | [Find List](#) | [New Search](#) | [Close](#)

[Demographics](#) | [Service](#) | [Annual Review](#) | [Encounters](#) | [Referrals](#) | [HIV C&T](#) | [Relations](#) | [NC-LINK](#) | [Custom Tab 2](#) | [Custom Tab 3](#) | [Subform](#) | [Scheduler](#)

Add/Edit Referral Information

Referral Date: Type: Refer-To Provider: Add Requested Service Category Type: Referral Class:

Referral Status: Referral Complete Date: Referral Comments:

F3: Add/Edit Service

[F1: Add Referral](#) | [F2: Edit Referral](#) | [Del: Delete Referral](#)

Search 1 / 1

Direction	↓ Referral Date	Provider	Service Category	Status	Completed Date
Incoming	6/6/2013	Wake Forest University Health Science...	Medical Case Management	Pending	

Using data from NCEDSS, enter or correct data in CAREWare on the following screens (or tabs):

➤ **Demographic tab**

(Confirm any data to be entered on this screen with what is in the client's NCEDSS record)

- On the left side of the screen with the address information, list the **home phone number** if known. On the right side of the screen, in the Common Notes field, enter the cell phone and/or work phone if known.
- On the left side of the screen **in the NCEDSS# field, enter the patient's NCEDSS ID number.**
- Gender: Indicate the client's gender (the socially and psychologically constructed, understood, and interpreted set of characteristics that describe the current sexual identity of an individual) based on his or her self-report.
- If a client address changes, make the change on this screen and make note of the change in the common notes field.
- Complete all other data fields on this screen, including the HIV+ date and the AIDS date from NCEDSS.

The screenshot shows the 'Demographics' tab for a client named Fred Izza. The form is divided into several sections:

- Personal Information:** First Name (Fred), Middle Name (Izza), Last Name (Testerman), Gender (Male), Date of Birth (1/1/1960), Sex at Birth (Male), Encrypted UCI (35BE370F3A19012DA400D9B25CA9C891866764F3U).
- Identification:** Unique ID (FETS0101601U), Encrypted URN (pXbmzYksl), Client ID, NCEDSS #.
- Enrollment:** Enrollment Status (Referred or Discharged), Enrollment Date (5/20/2014), Case Closed Date (5/20/2014), Vital Status (Alive), Date of Death.
- HIV/AIDS Status:** HIV Status (HIV-positive (AIDS status)), HIV+ Date (1/1/2012), AIDS Date.
- HIV Risk Factors:** Heterosexual Contact.
- Address:** Street Address (123 Cooper St), City (Raleigh), State (North Carolina), Zip Code (00000), County (New Hanover), Phone Number.
- Race/Ethnicity:** Race(s) (White), Ethnicity (Hispanic), Hispanic Subgroup.
- Common Notes:** 3/10/14: Referral closed in Raleigh SBC domain as last known address indicates that the Winston Salem SBC should work the case. File was sent to Winston Salem SBC. R.Jensen
09/22/2014: Client moved to Raleigh AME.
2/3/2015: Setup Wizard completed - BB

➤ **Demographics tab, cont'd**

When opening a record:

- Make sure the **Vital Status** is **Alive**. Select **Active** for the **Enrl Status** while you are working on the case.
- **Enrl Date** refers to the date the SBC received the client record via CAREWare referral, NCEDSS, or any other method.

Appointments		Orders	Forms	ChangeLog	Client Report	Merge Client	Delete Client	Find List	New Search	Close			
Demographics	Service	Annual Review	Encounters	Referrals	HIV C&T	Relations	Custom Tab 1	Custom Tab 2	Custom Tab 3	Subform	Scheduler	Per	
First Name:	Middle Name:	Unique ID		Enrollment Status:		Enrollment Date:		Case Closed Date:					
Fred	Izza	FETS0101601U		Active		3/22/2012							
Last Name:		Encrypted URN:		Vital Status:		Date of Death:							
Testeman		pXbmzYksl		Alive									
Gender:	Date of Birth:	Est?	HIV Status:		HIV+ Date:		Est?	AIDS Date:		Est?			
Male	1/1/1960	<input type="checkbox"/>	HIV Positive (AIDS status)		1/1/2012		<input type="checkbox"/>			<input type="checkbox"/>			
Sex at Birth:	Encrypted UCI:		HIV Risk Factors:										
	35BE370F3A19012DA400D9B25CA9C891866764F3U		Heterosexual Contact										
Client ID:				Common Notes		Provider Notes		User Messages		Case Notes			
9991212													
Street Address:		<input type="checkbox"/> Include on label report		Cell phone:		Work phone:							
123 Cooper St													
City:	State:	Zip Code:		3/10/14: Referral closed in Raleigh SBC domain as last known address indicates that the Winston Salem SBC should work the case. File was sent to Winston Salem SBC. R.Jensen		09/22/2014: Client moved to Raleigh AMF		2/3/2015: Setup Wizard completed - BB					
Raleigh	North Carolina	00000											
County:	Phone Number:												
New Hanover													
Race(s):													
White													
Ethnicity:		Hispanic Subgroup:											
Hispanic													

NC-LINK tab

Complete all data fields, selecting the appropriate choices from the drop-down boxes. For **‘TOTAL number of minutes spent looking for patient’** enter the sum (in minutes) of all the time you spent trying to locate the client (for an out-of-care referral). **Remember**, if you do not locate the client, leave the ‘If patient was located, how was patient found?’ field blank.

Appointments	Orders	Forms	ChangeLog	Client Report	Merge Client	Delete Client	Find List	New Search	Close			
Demographics	Service	Annual Review	Encounters	Referrals	HIV C&T	Relations	NC-LINK	Custom Tab 2	Custom Tab 3	Subform	Scheduler	Perform
Type of BC Referral	Other type of BC Referral, specify	New Case:	Previous Case:									
Out-of-care			NC case									
Patient referred to SBC by	Has patient ever accessed care?	If patient was located, how was patient found?										
Medical Provider	Yes	Clinic medical records										
Patient found by other means, specify:	TOTAL number of minutes spent looking for patient	2. Second SBC Referral date										
	20											
2. Type of BC Referral	2. Other type of BC Referral, specify	2. New Case:	2. Previous Case:									
2. Patient referred to SBC by	2. Has patient ever accessed care?	2. If patient was located, how was patient found?										
2. Patient found by other means, specify:	2. TOTAL number of minutes spent looking for pt											

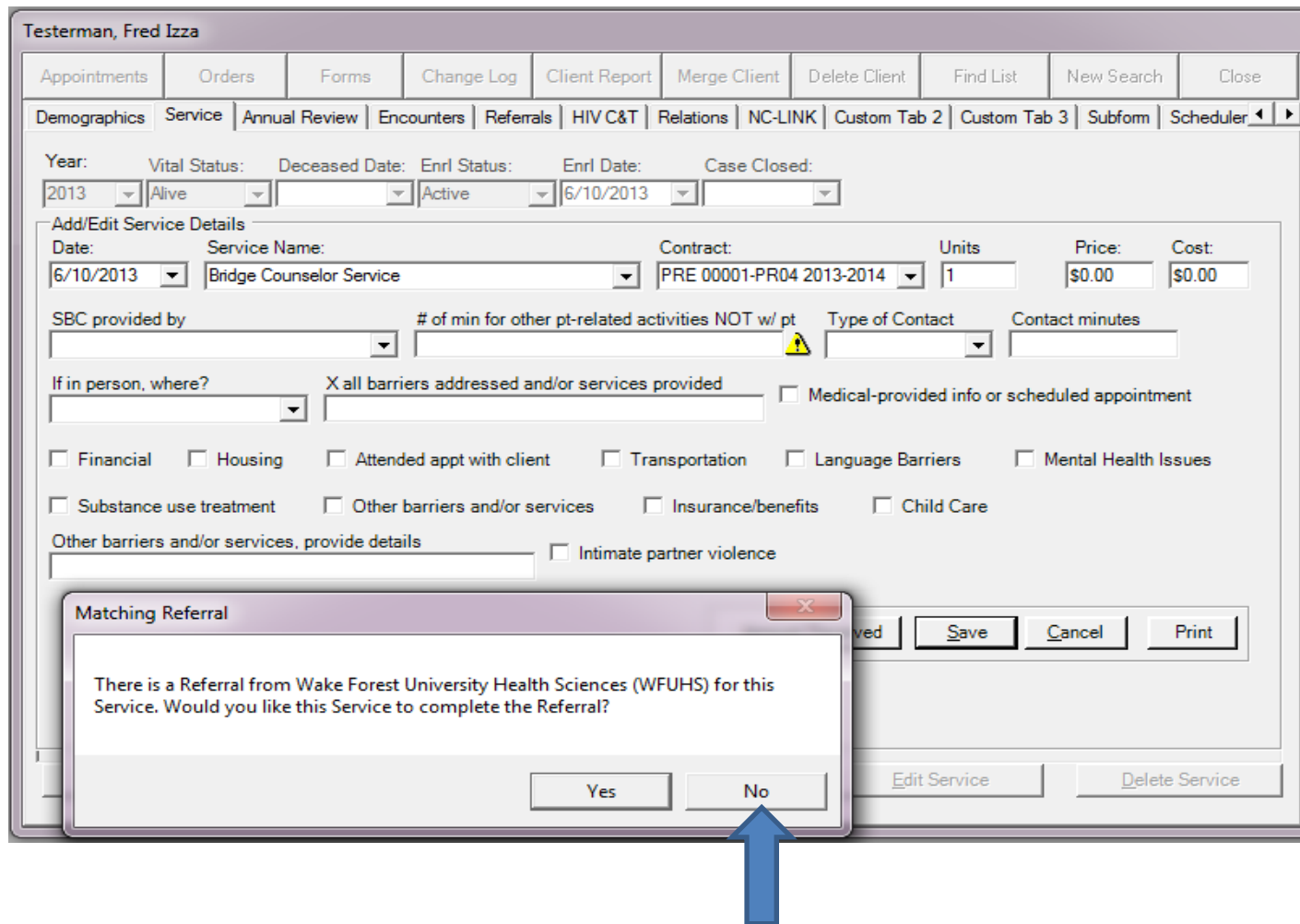
After locating an out-of-care client, EVERY time the SBC works on a client record a Bridge Counselor Service should be entered in CAREWare. This may require multiple entries on a single day:

- Enter a *Bridge Counselor Service* sub-service in CW for that client, entering data in all custom service fields.
 - SBC Provided by (select your name)
 - # of min for other pt-related activities NOT w/ pt (list the number of minutes you spent working on activities on behalf of the client, but not with the client)
 - Type of contact (refers to a contact WITH the client, if there was one that day. If there was no contact with the client leave this field blank)
 - If in person, where? (refers to the location of the in person contact with the client. If there was no contact with the client leave this field blank)
 - # of min providing strength-based counseling (If any. If not, leave blank)
 - # of min addressing barriers with patient (If any. If not, leave blank)
 - Total contact minutes (refers to the TOTAL number of minutes you spent in direct contact with the client. (If any. If not, leave blank)
 - X all barriers addressed and/or services provided (No data is entered here- this field is simply to provide directions about the boxes that follow)

The screenshot displays the 'Add/Edit Service Details' form within the CAREWare application. The form is organized into several sections:

- Navigation Bar:** Includes tabs for Appointments, Orders, Forms, Change Log, Client Report, Merge Client, Delete Client, Find List, New Search, and Close.
- Demographics:** Includes tabs for Demographics, Service, Annual Review, Encounters, Referrals, HIV C&T, Relations, NC-LINK, Custom Tab 2, Custom Tab 3, Subform, and Scheduler.
- Filters:** Fields for Year (2013), Vital Status (Alive), Deceased Date, Enrl Status (Active), Enrl Date (3/27/2013), and Case Closed.
- Add/Edit Service Details:**
 - Date:** 6/28/2013
 - Service Name:** Bridge Counselor Service
 - Contract:** PRE 00001-PR01 2013-2014
 - Units:** 1
 - Price:** \$0.00
 - Cost:** \$0.00
 - SBC provided by:** (Dropdown menu)
 - # of min for other pt-related activities NOT w/ pt:** (Text input)
 - Type of Contact:** (Dropdown menu)
 - If in person, where?:** (Dropdown menu)
 - # of min providing strength-based counseling:** (Text input)
 - # of min addressing barriers with patient:** (Text input)
 - Total contact minutes:** (Text input)
 - X all barriers addressed and/or services provided:** (Text input)
 - Medical-provided info or scheduled appointment
 - Attended appt with client
 - Financial
 - Housing
 - Transportation
 - Substance use treatment
 - Mental Health Issues
 - Insurance/benefits
 - Language Barriers
 - Child Care
 - Intimate partner violence
 - Other barriers and/or services
 - Other barriers and/or services, provide details:** (Text input)

- When a bridge counselor service is entered, CAREWare may display a pop-up window that says “There is a referral from XXX for this service. Would you like this service to complete the referral?” Check **NO** until it is time to close the referral and the client record.
- Part B funded SBCs have additional sub-services to enter based on their Part B requirements.



- When the SBC is ready to close the client record, follow these 3 steps:
 1. Make sure that all appropriate data fields are complete on the **NC-LINK tab**.
 2. Enter a **Bridge Counseling Service Outcome** sub-service, entering data in all custom service fields.
 - If there are details like an appointment date or the fact that a patient was re-engaged in care at a different provider than the one that sent the referral, etc. enter that information in the **Outcome Comments** field.


Appointments	Orders	Forms	Change Log	Client Report	Merge Client	Delete Client	Find List	New Search	Close		
Demographics	Service	Annual Review	Encounters	Referrals	HIV C&T	Relations	NC-LINK	Custom Tab 2	Custom Tab 3	Subform	Scheduler

Year: 2013 Vital Status: Alive Deceased Date: Enrl Status: Active Enrl Date: Case Closed:

Add/Edit Service Details

Date:	Service Name:	Contract:	Units:	Price:	Cost:
6/21/2013	Bridge Counseling Service Outcome	PRE 00001-PR03 2013-2014	1	\$0.00	\$0.00

Outcome of State Bridge Counseling: Outcome Comments: SBC provided by:

Deceased Incarcerated Located, not re-engaged in care to date Re-engaged in care at referring provider Re-engaged in care with new provider Re-located Unknown-not located		Amount Received Save Cancel Print
--	--	-----------------------------------

2 (cont'd) When you click 'Save', a pop-up box may appear stating **"There is a Referral from XXX for this service. Would you like this service to complete the referral?"** Check **YES**. This will flip the 'pending' referral to 'completed' and it will drop off the list viewed from the Main Menu screen. Completed referrals can still be tracked in CAREWare using the Referrals report.

The screenshot shows the CAREWare interface for a client named Fred Izza. The main window has a menu bar with options like 'Appointments', 'Orders', 'Forms', 'Change Log', 'Client Report', 'Merge Client', 'Delete Client', 'Find List', 'New Search', and 'Close'. Below the menu bar, there are tabs for 'Demographics', 'Service', 'Annual Review', 'Encounters', 'Referrals', 'HIV C&T', 'Relations', 'NC-LINK', 'Custom Tab 2', 'Custom Tab 3', 'Subform', and 'Scheduler'. The 'Service' tab is active, showing 'Add/Edit Service Details' with fields for Date (6/10/2013), Service Name (Bridge Counseling Service Outcome), Contract (PRE 00001-PR04 2013-2014), Units (1), Price (\$0.00), and Cost (\$0.00). There are also buttons for 'Amount Received', 'Save', 'Cancel', and 'Print'. A pop-up dialog box titled 'Matching Referral' is overlaid on the main window, containing the text: 'There is a Referral from Wake Forest University Health Sciences (WFUHS) for this Service. Would you like this Service to complete the Referral?' and two buttons: 'Yes' and 'No'. A blue arrow points to the 'Yes' button.

3. On the Demographics tab, change the **Enrl Status** to the most appropriate choice based on your findings; **Incarcerated, Relocated, or Referred or Discharged**. Use the *Referred or Discharged* option for all closure situations except *Incarcerated or Relocated*. Enter the date you complete your work on the client record in the **Case Closed:** field. This date should match the date of the Bridge Counseling Service Outcome entry. Change the **Vital Status** if the client is found to be deceased. Also enter the **Deceased Date**, if known.

Testerman, Fred Izza

Appointments Orders Forms ChangeLog Client Report Merge Client Delete Client Find List New Search Close

Demographics Service Annual Review Encounters Referrals HIV C&T Relations **Enrollment** Custom Tab 2 Custom Tab 3 Subform Schedule Performance

First Name: Fred Middle Name: Izza Unique ID: FETS0101601U
Last Name: Testerman Encrypted URN: pXbmzYksl
Gender: Male Date of Birth: 1/1/1960 Est?
Sex at Birth: Encrypted UCI: 35BE370F3A19012DA400D9825CA9C891866764F3U
Client ID: NCEDSS #
Street Address: 123 Cooper St Include on label report

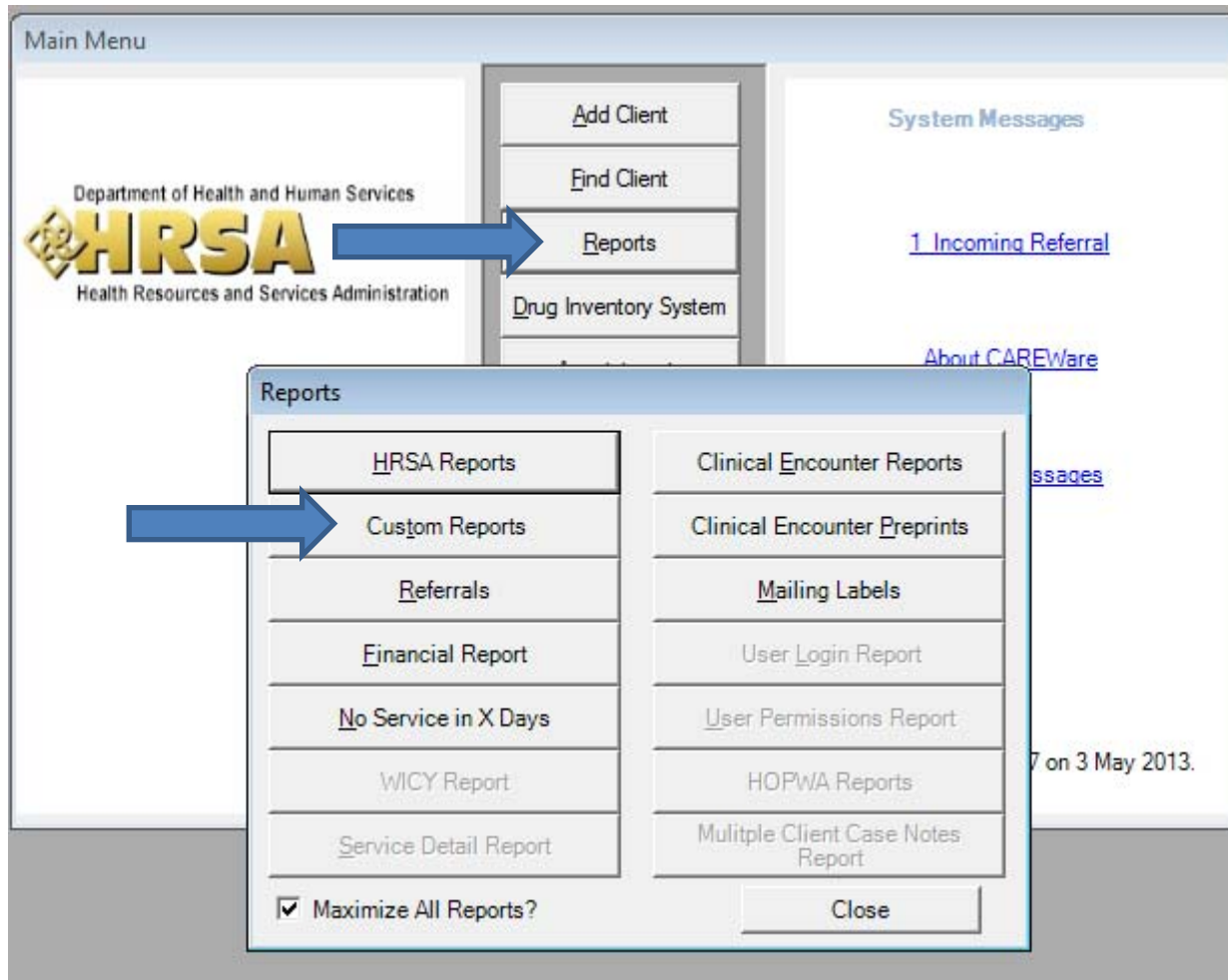
Enrollment Status: Referred or Discharged Enrollment Date: 5/20/2014 Case Closed Date: 5/20/2014
Vital Status: Alive Date of Death:
HIV Status: HIV-positive (AIDS status) HIV+ Date: 1/1/2012 Est? AIDS Date: Est?
HIV Risk Factors: Heterosexual Contact

Common Notes Provider Notes User Messages Case Notes
Cell phone:
Work phone:

Completing these 3 steps will close the client record in your SBC domain.

Active Client Work List Report

To track ALL active client records (those received via electronic referral AND those received via NCEDSS, phone, or fax that have been entered manually into CW) in an SBC domain, a custom report can be run and used as a work list.



Highlight the report named **NCL-RJ- Active Client Work List**, clear out any date spans and make sure that the Clinical Review Year is set to the current year. Click **Run Report**.

The screenshot shows the 'Custom Reports' window. The 'View/Edit' section contains a 'Data Scope' box with three unchecked options: 'Show Shared Service Records', 'Show Shared Clinical Records', and 'Show Shared Custom Subform Records'. To the right, there is a 'Filter Report Type:' dropdown menu, a 'Date Span' section with 'From:' and 'Through:' dropdowns, and a 'Clinical Review Year:' dropdown menu. Below these are three checkboxes: 'Show New Clients Only' (unchecked), 'Show Specifications' (checked), and 'Sum Numeric Fields' (unchecked). A table below lists reports with columns for 'Report Name:', 'Report Type:', and 'Custom/Crosstab:'. The first row is highlighted in blue and contains 'NCL-RJ- Active Client Work List', 'Demographics', and 'Custom'. To the right of the table is a vertical stack of buttons: 'Run Report', 'New Report', 'Delete Report', 'Edit Report', 'Copy Report', 'Import From File', 'Export To File', and 'Close'. Blue arrows point to the 'Report Name:' field, the 'Filter Report Type:' dropdown, the 'Date Span' fields, and the 'Run Report' button.

Report Name:	Report Type:	Custom/Crosstab:
NCL-RJ- Active Client Work List	Demographics	Custom

The SBC Active Client Work List will appear like the screen shot below. This report can be viewed, printed or exported to Excel or other formats by clicking the second to the left icon in the upper left corner.

The screenshot shows a web application interface. At the top, there is a menu bar with the word "File" on the left. Below the menu bar is a toolbar containing several icons. Three blue arrows point to the first three icons from the left: a document icon, a PDF icon labeled "View As PDF", and a printer icon labeled "Print...". To the right of these icons are zoom controls showing "100%", a page indicator showing "1/1", and "Backward" and "Forward" navigation buttons. Below the toolbar is a horizontal scroll bar. The main content area displays the following information:

NCL-RJ- Active Client Work List

Data Scope: Raleigh Bridge Counselor

Report Criteria:
Enrl Status: Active

Name: Testerman, Fred Izza **Client ID:**

Number of Records **1**
(Count is unduplicated across providers)

* - *Restricted Field*

SBC CAREWare process steps for tracking referrals that move from one SBC to another

Example: A referral is received by the SBC via CAREWare, paper, fax, etc. The SBC notes that the last known address for the client is in another SBC's region.

1. The receiving SBC enters the record into CAREWare or receives the referral into their domain if it was sent via CAREWare
2. **If** the last known address in the client record is outside of the SBC's region, the record will need to be closed by the receiving SBC and referred to the appropriate SBC. The SBC who first received the referral will:
 - a. On the NCLINK tab, complete all appropriate fields.
 - b. Then, click on *Add Referral* to send the client record to the appropriate SBC.

The screenshot displays the 'NCLINK' tab in the CAREWare software. The interface includes a top navigation bar with buttons for 'Appointments', 'Orders', 'Forms', 'ChangeLog', 'Client Report', 'Merge Client', 'Delete Client', 'Find List', 'New Search', and 'Close'. Below this is a secondary navigation bar with tabs for 'Demographics', 'Service', 'Annual Review', 'Encounters', 'Referrals', 'HIV C&T', 'Relations', 'NC-LINK', 'Custom Tab 2', 'Custom Tab 3', 'Subform', 'Scheduler', and 'Perform:'. The main content area contains several sections of data entry fields:

- Referral Type:** 'Type of BC Referral' (dropdown: Out-of-care), 'Other type of BC Referral, specify' (text input), 'New Case:' (dropdown), and 'Previous Case:' (dropdown: NC case).
- Referral Source:** 'Patient referred to SBC by' (dropdown: Medical Provider), 'Has patient ever accessed care?' (dropdown: Yes), and 'If patient was located, how was patient found?' (dropdown: Clinic medical records).
- Search Details:** 'Patient found by other means, specify:' (text input), 'TOTAL number of minutes spent looking for patient' (text input: 20), and '2. Second SBC Referral date' (dropdown).
- Secondary Referral Section:** A duplicate set of fields labeled '2.' for 'Type of BC Referral', 'Other type of BC Referral, specify', 'New Case:', 'Previous Case:', 'Patient referred to SBC by', 'Has patient ever accessed care?', 'If patient was located, how was patient found?', 'Patient found by other means, specify:', and 'TOTAL number of minutes spent looking for pt'.

1. Referral Date: = current date. Type: = Internal. Refer-To Provider: = Select the appropriate SBC domain to send the referral to (Black Mountain Bridge Counselor, Charlotte Bridge Counselor, Fayetteville Bridge Counselor, Greenville Bridge Counselor, NC Dept of Health and Human Svcs (NCDHHS-C, or NCDHHS-R, or NCDHHS-W) –these are *the Special Populations SBC domains*, Raleigh Bridge Counselor, Wilmington Bridge Counselor, Winston Salem Bridge Counselor). Requested Service Category Type: = Medical Case Management. Referral Class: = leave blank. Referral Comments: = “Transferring referral to region of client’s last known address” or something similar.
2. Click Save. This will save the referral and send it on to the appropriate SBC.

Appointments | Orders | Forms | Change Log | Client Report | Merge Client | Delete Client | Find List | New Search | Close

Demographics | Service | Annual Review | Encounters | Referrals | HIV C&T | Relations | NC-LINK | Custom Tab 2 | Custom Tab 3 | Subform | Scheduler

Add/Edit Referral Information

Referral Date: [] Type: [] Refer-To Provider: [] Add Requested Service Category Type: [] Referral Class: []

Referral Status: [Pend] Referral Complete Date: [] Referral Comments: []

Silent Referral Save Cancel

- c. Then, click on the Service tab. Enter a *Bridge Counseling Service Outcome* service. In the 'Outcome of Bridge Counseling' box, select "Transferred to another SBC". When you click 'Save', a pop-up box may appear stating "**There is a Referral from XXX for this service. Would you like this service to complete the referral?**" Check **YES**. This will flip the 'pending' referral to 'completed' and it will drop off the list viewed from the Main Menu screen.

Appointments	Orders	Forms	Change Log	Client Report	Merge Client	Delete Client	Find List	New Search	Close		
Demographics	Service	Annual Review	Encounters	Referrals	HIV C&T	Pregnancy	Relations	NC-LINK	Custom Tab 2	Custom Tab 3	Subform
Year:	Vital Status:	Deceased Date:	Enrl Status:	Enrl Date:	Case Closed:						
2014	Alive		Active	1/21/2014							
Add/Edit Service Details											
Date:	Service Name:	Contract:	Units	Price:	Cost:						
5/22/2014	Bridge Counseling Service Outcome	PRE 00001-PR01 2014-2015	1	\$0.00	\$0.00						
Outcome of Bridge Counseling:	Outcome Comments:	SBC provided by									
Medical Provider Name											
Amount Received				Save		Cancel		Print			

- d. Then, click on the Demographics tab. Enrl Status: = Referred or Discharged. Case Closed: = current date. This will close the record in the 1st (receiving) SBCs domain.

Testerman, Fred Izza

Appointments Orders Forms ChangeLog Client Report Merge Client **Delete Client** Find List New Search Close

Demographics Service Annual Review Encounters Referrals HIV C&T Relations NC-D Custom Tab 2 Custom Tab 3 Subform Scheduler

First Name: Fred Middle Name: Izza Unique ID: FETS0101601U
Last Name: Testerman Encrypted URN: pXbmzYksl
Gender: Male Date of Birth: 1/1/1960 Est?
Sex at Birth: Encrypted UCI: 35BE370F3A19012DA400D9B25CA9C891866764F3U
Client ID: NCEDSS #
Street Address: 123 Cooper St Include on label report

Enrollment Status: Referred or Discharged Enrollment Date: 5/20/2014 Case Closed Date: 5/20/2014
Vital Status: Alive Date of Death:
HIV Status: HIV-positive (AIDS status) HIV+ Date: 1/1/2012 Est? AIDS Date: Est?
HIV Risk Factors: Heterosexual Contact

Common Notes Provider Notes User Messages Case Notes
Cell phone:
Work phone:

- e. Then, still on the Demographics tab enter a comment in the Common Notes field to alert the next viewer about the transfer from one SBC to another. The comment could be something like: “3/10/14: Referral closed in Raleigh SBC domain as last known address indicates that the Winston Salem SBC should work the case. File was sent to Winston Salem SBC. R.Jensen”

The screenshot shows a patient record for Fred Izza Testerman. The 'Common Notes' section contains the following text:

- 3/10/14: Referral closed in Raleigh SBC domain as last known address indicates that the Winston Salem SBC should work the case. File was sent to Winston Salem SBC. R.Jensen
- 09/22/2014: Client moved to Raleigh AMF
- 2/3/2015: Setup Wizard completed - BB

A blue arrow points to the first note.

- f. The SBC that receives the referral will work it like any other referral, following the standard process steps.

APPENDIX M: Retention Protocol- NC-LINK Sites

NC-LINK Patient Retention Protocol

Definition of Out of Care:

“An active patient who has not had a medical visit in 6-9 months or more”

Monthly Protocol

1. The clinic designee will run a report in CAREWare or in the provider’s electronic medical record software on the 1st of each month (or closest business day to the 1st) of all patients with “Active” status with no medical visit in 9 months or more.
2. The HIT Coordinator or designee will place referrals for bridge counseling services into CAREWare using the process outlined in Attachment A.
3. The Clinic-based/Regional Retention Staff, aka Patient Navigator, Medical Case Manager, Access Coordinator, Linkage Retention Coordinator, etc. will conduct bridge counseling activities. They will conduct their activities using at a minimum, the following comprehensive search processes:
 - Check EMR/local CAREWare for any contact since the last medical visit
 - Call patient’s home/cell/work numbers in the chart as well as any old numbers that are in the chart in case they are active again. Three phone calls on three separate days will be the standard.
 - Ensure that generic messages are left for callback for privacy purposes
 - Do internet search of local jails, state prisons, federal prison system:
 - <https://www.vinelink.com>
 - <https://www.doc.state.nc.us/offenders/>
 - Check the Social Security death Index and a Google search for potential obituaries and other information about the patient
 - www.pipl.com
 - www.ancestry.com
 - Check the NC Medicaid Provider Portal to see if they have been in care elsewhere, accessed EDs or had an inpatient stay, and if there is different contact info in the record
 - Call last pharmacy and see if any other refills have occurred since last medical visit and get any contact info available or info on other prescribing providers
 - Call any home health agency/dialysis center/or other provider you can identify to obtain current contact info or get a message through to the patient
 - Send out a generic letter to last known address encouraging patient to get in touch with us if no phone calls have been successful
4. Retention Staff will document all bridge counseling efforts in CAREWare according to the process in Attachment A.

5. At the end of the month, the Retention Staff 'resolve' all their current referrals by completing the case closure process according to the process in Attachment A. Upon completion of this process by the Retention Staff, the HIT Coordinator or designee at the referring agency will review all client records that have been resolved by the Retention Staff. Those client records with a bridge counselor service outcome of "Located, not re-engaged in care to date or Unknown-not located" will be referred to the State Bridge Counselor (SBC). Additionally, the HIT Coordinator or designee will review the outcomes of all the other client cases that were completed by the Retention Staff and ensure enrollment statuses are updated as appropriate per the findings of the Retention Staff.
6. Once the State Bridge Counselor completes their bridge counseling activities, the HIT Coordinator or designee will again review the outcomes of all the client cases completed by the SBC and ensure enrollment statuses are updated as appropriate per the SBCs findings.

APPENDIX N: Retention Protocol- Non NC-LINK Sites

Patient Retention Protocol for Non NC-LINK Sites

Definition of Out of Care:

“An active patient who has not had a medical visit in 6 months or more”

This protocol is recommended to clinics prior to referring patients to the State Bridge Counselor (SBC)

1. A report or list of out-of-care patients should be generated by the clinic monthly.
2. The list should be provided to the Retention Staff, aka Patient Navigator, Medical Case Manager, Access Coordinator, Linkage Retention Coordinator, etc. to conduct bridge counseling activities. They should conduct (at a minimum) the following search processes:
 - Check EMR/local CAREWare for any contact since the last medical visit
 - Call patient’s home/cell/work numbers in the chart as well as any old numbers that are in the chart in case they are active again. Three phone calls on three separate days should be the standard.
 - Ensure that generic messages are left for callback for privacy purposes
 - Do internet search of local jails, state prisons, federal prison system
 - <https://www.vinelink.com>
 - <https://www.doc.state.nc.us/offenders/>
 - Check the Social Security death Index and a Google search for potential obituaries and other information about the patient
 - www.pipl.com
 - www.ancestry.com
 - Check the NC Medicaid Provider Portal to see if they have been in care elsewhere, accessed EDs or had an inpatient stay, and if there is different contact info in the record
 - Call last pharmacy and see if any other refills have occurred since last medical visit and get any contact info available or info on other prescribing providers
 - Call any home health agency/dialysis center/or other provider you can identify to obtain current contact info or get a message through to the patient
 - Send out a generic letter to last known address encouraging patient to get in touch with us if no phone calls have been successful
3. After the above searches are conducted, any patients who are unknown or unable to be located should be referred to the State Bridge Counselor (SBC).
4. Patients who are located but have significant barriers to engaging in care may also be referred to the SBC.
5. The SBC is responsible for communicating back to the clinic after his/her attempts to find and re-engage the patient.

APPENDIX O: NC-LINK Retention Staff Intervention Tracking in CAREWare

NC-LINK tab

Custom tab- fields set up on each domain:

- **RBC Referral Date:**
 - Date picker box

- **Social Security Number**
 - Text box

- **If patient was located, how was patient found?**
 - Code: 18 Value: EMR/local CAREWare
 - Code: 19 Value: Call to home/cell/work
 - Code: 20 Value: Internet search of local jails/state & federal prisons
 - Code: 21 Value: Social Security death index
 - Code: 09 Value: Internet search
 - Code: 22 Value: NC Medicaid Provider portal
 - Code: 23 Value: Last known pharmacy
 - Code: 24 Value: Contact other providers
 - Code: 25 Value: Letter to last known address
 - Code: 17 Value: Other

- **Patient found by other means, specify:**
 - Text box

- **TOTAL number of minutes spent looking for patient**
 - This is a number field, accepting no more than 3 digits

- **RBC Referral Closed Date:**
 - Date picker box

Service tab

Sub-service custom fields

Two sub-services with custom service fields set up on each domain:

Bridge Counselor Service subservice with custom service fields:

- **BC Provided by:**
 - Code: Value:
 - Code: Value:
 - Code: Value:

- **Navigator type**
 - Code: 01 Value: MD
 - Code: 02 Value: RN
 - Code: 03 Value: Clinic staff
 - Code: 04 Value: Social worker
 - Code: 05 Value: Peer Navigator/linkage personnel
 - Code: 06 Value: Non-Peer Navigator/linkage personnel
 - Code: 07 Value: Case Manager
 - Code: 08 Value: DIS
 - Code: 09 Value: Other

- **If other Navigator type, specify:**
 - Text box

 - **# of min for other pt-related activities NOT w/pt**
 - This is a number field, accepting no more than 3 digits

- **Type of contact**
 - Code: 01 Value: Phone
 - Code: 02 Value: In-Person
 - Code: 03 Value: Text Message
 - Code: 04 Value: Email
 - Code: 05 Value: Postal Mail

- **If in person, where?**
 - Code: 01 Value: Clinic
 - Code: 02 Value: Home
 - Code: 03 Value: Community-Based Org
 - Code: 04 Value: Other

- **Total contact minutes**
 - This is a number field, accepting no more than 3 digits

- **X all barriers addressed and/or services provided**
 - This box is simply an instruction box, no data entry required

- **Initial screening with navigator**
 - Checkbox

- **Case management service**
 - Checkbox

- **Medical-provided info or scheduled appointment**
 - Checkbox

- **Attended appt with client**
 - Checkbox

- **Financial**
 - Checkbox

- **Housing**
 - Checkbox

- **Transportation**
 - Checkbox

- **Substance use treatment**
 - Checkbox

- **Mental Health Issues**
 - Checkbox

- **Insurance/benefits**
 - Checkbox

- **Language Barriers**
 - Checkbox

- **Child Care**
 - Checkbox

- **Intimate partner violence**
 - Checkbox

- **Other barriers and/or services**
 - Checkbox

- **Other barriers and/or services, provide details**

- Text box

Bridge Counseling Service Outcome subservice with custom service fields:

- **Outcome of Bridge Counseling:**
- Code: 02 Value: Deceased
- Code: 03 Value: Re-located
- Code: 04 Value: Incarcerated
- Code: 05 Value: Located, not re-engaged in care to date
- Code: 06 Value: Unknown-not located
- Code: 07 Value: Re-engaged in care at referring provider.
- Code: 08 Value: Re-engaged in care with new provider

- **Outcome Comments:**
- Text box

- **BC Provided by**
- Code: Value:
- Code: Value:
- Code: Value:

APPENDIX P: Retention Intervention Process and Service Detail

	Protocol	Process/Service
1	On or near the first day of the month, an Out of Care report is run to list all patients who have not had a medical care visit in 9 months or more	
2	Out of Care referrals are placed into CAREWare for bridge counseling services	<p>Someone at referring agency enters the <i>internal referral</i> for each client being referred to a RBC using the referral tab in CAREWare or otherwise refers the clients to the RBC. Directions for completing the RBC OOC referral on the CW referral tab: Enter the referral to the RBC as <i>Medical Case Management</i> in the ‘Requested Service Category Type’ field. Select the appropriate referral date then select the appropriate provider in the ‘Refer-To-Provider’ field. Leave the ‘Referral Class’ field blank. In the ‘Referral Comments’ field enter <i>Out of Care referral to RBC.</i></p> <p>OR</p> <p>Someone at referring agency enters a <u>RBC Referral Date</u> in the appropriate date picker box for each client record being referred for internal Regional Bridge Counseling services.</p> <p><i>Referrals in CAREWare can be tracked. Reports can be created by going to the main menu in CAREWare, clicking ‘Reports’ then selecting ‘Referrals’ if the referral was sent via the electronic referral functionality. If the referral was sent internally, using the RBC Referral Date method, a custom report listing all open RBC referrals can be run by clicking ‘Reports’ then selecting ‘custom reports’ then selecting the appropriate custom report.</i></p> <p>THEN, if appropriate, someone at the referring agency enters the sub-service “<u>OOO Referral to Bridge Counseling</u>” in CW on the referring agency domain in each client record that appears on the spreadsheet to be referred to a RBC.</p>

3	Retention Staff conduct bridge counseling activities according to the retention protocol and document all bridge counseling efforts in CAREWare	<p>The RBC will review, enter and correct information on the <u>Demographics tab</u>, the <u>NC-LINK tab</u>, the <u>Annual Review tab</u>, and the <u>Service tab</u> in CAREWare.</p> <p><u>Demographics tab</u>: In the common notes field enter any additional contact phone numbers. Also, if a client address changes, correct the information in the appropriate fields and note the date of the address change with your name or initials. Complete all other fields on this screen.</p> <p><u>NC-LINK tab</u>: Complete all data fields on this screen.</p> <p><u>Annual Review tab</u>: Click on the + next to HIV Risk Reduction Counseling and then select the most appropriate response for Result and Counseled by. Enter any information about the client’s health insurance in the same manner, if known.</p> <p><u>Service tab</u>: After locating the client, each time a RBC works on a client record they enter the “<u>Bridge Counselor Service</u>” in CW on each client record on the, completing all custom service fields. <i>When a bridge counseling service or any other service in the medical case management category is entered, CAREWare may display a pop-up window that says “There is a Referral from XXX for this service. Would you like this service to complete the referral?” Check NO until it is time to close out the referral.</i></p> <p><i>Referrals in CAREWare can be tracked. Reports can be created by going to the main menu in CAREWare, clicking ‘Reports’ then selecting ‘Referrals’ if the referral was sent via the electronic referral functionality. If the referral was sent internally, using the RBC Referral Date method, a custom report listing all open RBC referrals can be run by clicking ‘Reports’ then selecting ‘custom reports’ then selecting the appropriate custom report.</i></p>
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4	<p>By the end of each month, Retention Staff will have a list of those clients who were found to be</p> <ul style="list-style-type: none"> • Re-engaged in care at referring provider • Re-engaged in care with new provider • Deceased • Re-located • Incarcerated • Located, not re-engaged in care to date • Unknown-not located 	<p>At the end of the month, the Retention Staff or designee should appropriately close the records for those clients who were found to be Re-engaged in care with new provider, Deceased, Re-located, Incarcerated, or Unknown-not located in their provider domain, using the following 4 steps:</p> <ol style="list-style-type: none"> 1. Make sure that all data fields are complete on the NC-LINK tab. 2. Enter a “Bridge Counseling Service Outcome” service on the <u>Service tab</u> in CAREWare for each client that was referred to them for Bridge Counseling that month. Complete all custom service fields. <i>When this service is entered CAREWare may display a pop-up window that says “There is a Referral from XXX for this service. Would you like this service to complete the referral?” Check YES. This will flip the ‘pending’ referral to ‘completed’ and it will drop off the list viewed from the Main Menu screen.</i> Completed referrals can still be tracked in CAREWare using the Referrals report. If the referral was received using the RBC Referral Date functionality, a custom report can be run to track all completed referrals by date closed. 3. On the <u>Service tab</u>, change the Enrl Status to the most appropriate choice based on your findings; <i>Referred or Discharged, Incarcerated, or Relocated</i>. Enter the date you complete your work on the client record in the Case Closed: field. Change the Vital Status if the client is found to be deceased. Also enter the Deceased Date, if known. 4. On the <u>Annual Review tab</u>, click on the + next to HIV Risk Reduction Counseling and then select the most appropriate response for Result and Counseled by. Enter any information about the client’s health insurance in the same manner, if known.
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5	The enrollment status of those clients who the RBC's found to be Re-engaged in care with new provider, Deceased, Re-located, or Incarcerated will be changed in the referring provider's domain of CAREWare.	Someone at referring provider agency closes the client records appropriately in their provider domain. These closed client records can be re-opened if the client comes back to medical care at the referring provider agency.
6	The clients with an RBC outcome of Located, not re-engaged in care to date or Unknown-not located are referred to the appropriate SBC via CAREWare using the electronic referral functionality.	

APPENDIX Q: Patient Navigator Job Description

Job Title: Patient Navigator

JOB SUMMARY

Support the efforts of the Ryan White Program by increasing enrollment, engagement, and retention in care of HIV positive patients at the Medical Center. Serve as a conduit for these patients to accessing HIV medical care and medical specialty services as well as community resources. Additionally acts as primary financial resource for HIV patients.

ESSENTIAL FUNCTIONS

- Responsible for increasing the enrollment, engagement, and retention in care of HIV infected patients of the Infectious Disease Specialty Clinic
- Assist uninsured patients with obtaining coverage through health insurance exchanges that will be available with the onset of the Affordable Care Act as well as other resources for health insurance coverage as they come available
- Function as a primary resource for patients on matters of financial issues and obtaining access to insurance coverage
- Perform duties such as screening patients to see if they qualify for the Ryan White program, review any billing questions or financial issues they may have, and conduct ongoing financial reviews for eligibility to financial assistance programs.
- Provide financial information to NCBH/WFUP billing departments as needed to make decisions on patient accounts
- Coordinate referrals for the Ryan White dental program for patients with no source of dental insurance coverage
- Interact with insurance companies to work through issues patients may encounter with their plans and assist patients with understanding what services their plans cover, particularly with medication access issues
- Connect patients to resources within the Medical Center and within the community in order to meet the patients' needs and barriers to care such as difficulties with medications, acceptance of diagnosis, social stigma, family issues, transportation issues etc.
- Maintain close communications and participate in case review with medical providers, community-based case managers, and the clinic Social Worker regarding the plan of care, patient condition, and the appropriate level of intervention
- Monitor new patient enrollments to support engagement and retention in care
- Complete ADAP and other patient assistance applications for eligible patients
- Analyze and address patient "no-show" trends, using innovative approaches to promoting retention in care
- Track and contact patients who do not keep initial appointments or have missed follow-up visits with the assistance of the clinic schedulers and coordinate outreach efforts in conjunction with case management agencies and the Social Worker
- Maintain documentation of patient interactions in the electronic medical record and in CAREWare and other data entry as needed.
- Conduct bridge counseling activities on an ongoing basis on patients who fall out of care using the clinic protocols

- Assist Clinical Quality Administrator with the coordination of quarterly Consumer Advisory Board events
- Performs and maintains competency for HIV point-of-care testing as assigned, ensuring compliance with WFBH/WFBMC policies and with applicable state and federal regulations
- Participate in the sectional Quality Management Program, including membership on the interdisciplinary Quality Committee
- Attend local, regional, and national meetings and trainings as needed
- Other duties as assigned

EDUCATION/EXPERIENCE

- Bachelor's degree in social work, sociology, public health, psychology, or equivalent combination of education and experience.
- Experience with the provision of care coordination services to patients from underserved populations with barriers to accessing and maintaining medical care

SKILLS AND QUALIFICATIONS

- Excellent interpersonal skills and ability to interact with Medical Center personnel in various departments as well as outside providers, community agencies, health departments, etc.
- Highly organized with the capacity for multitasking in a fast paced environment
- Excellent computer skills with the capacity to learn electronic medical record and scheduling systems quickly
- Knowledge of HIV/AIDS disease and/or experience working with people living with HIV a strong preference
- Strong familiarity of Forsyth and surrounding county transit systems
- Familiarity with dealing with cultural issues in diverse, underserved population.
- Bilingual in Spanish (preferred but not required)